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ABSTRACT

This monograph purports that American society limits the behavior of older individuals based on the arbitrary criterion of chronological age and proposes the concept of empowerment--gaining a sense of personal power or control over over's life--as the antidote for older persons who face devalued status as they age and the for the accompanying drop in self-esteem and self-worth. The concept of empowerment is explored in detail, developmental issues, the key to understanding the aging process are reviewed, and empowerment strategies are discussed through a holistic wellness model. Chapter 1 looks at aging and the need for empowerment, considering: demographic changes, gender and aging, health and disability, and the social context of aging. Chapter 2 examines self-efficacy and empowerment and presents models of helping and empowerment, while chapter 3 focuses on developmental and transition theories for later life. Chapter 4 concentrates on reactions to late life stress, looking at mental health and aging, the social breakdown syndrome, and psychological components of social breakdown. Chapter 5 suggests strategies for reversing the breakdown syndrome by presenting the social reconstruction model and discussing societal, psychological, and other aspects of reconstruction. Overcoming learned helplessness and perceived lack of control and coping with depression and discouragement are also addressed. Stages of the empowerment process are outlined. The final chapter considers empowerment through developmental approaches, with an emphasis on wellness. (NB)

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Empowerment for Later Life

Jane E. Myers

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Contents

Foreword v

About the Author vii

Prologue 1

Introduction 3

Chapter 1. Aging and the Need for Empowerment 7

- Demographic Changes, Personal Responses 7
- Gender and Aging: Lifespan, Marriage, Income, and Social Supports 9
- Health, Disability, and Aging 12
- The Social Context of Aging 14
- The Need for Empowerment 19

Chapter 2. Self-Efficacy and Empowerment 21

- Self-Efficacy and Behavior 21
- Defining Empowerment 28
- Models of Helping and Empowerment 30

Chapter 3. Developmental and Transition Theories for Later Life 35

- Theoretical Perspectives on Development in Later Life 36
- Developmental Theories 37
- Transition Theories 42

Chapter 4. Reactions to Late Life Stresses: Various Breakdown Patterns 51

- Mental Health and Aging 51
- The Social Breakdown Syndrome 53

Psychological Components of Social Breakdown 55

Chapter 5. Empowerment Through Remediation: Reversing the Breakdown Syndrome 65

The Social Reconstruction Model 65
Societal Aspects of Reconstruction 67
Other Components of Reconstruction 70
Psychological Aspects of Reconstruction....................74
Overcoming Learned Helplessness and Perceived Lack of Control....................75
Coping with Depression and Discouragement....................79
Stages of the Empowerment Process....................82

Chapter 6. Empowerment Through Developmental Approaches 87

Prevention and Empowerment....................88
The Wellness Philosophy....................90
Wellness in Six Dimensions 92
Wellness Aspects of Agencies and Settings 97
Wellness as a Lifespan Concern 98

Epilogue 101

References....................105

ERIC Resources 113

ERIC/CAPS....................119

CAPS Publications Available in 1990....................121

Foreword

In working with an author on a book there are usually incidents or experiences that you go through with the writer that help you as an editor frame in your own mind what is special or unique about that author. In the case of Jane Myers, two thoughts come to mind. First, is her "diamond cutter" approach to preparing a manuscript. She takes a subject and looks at it from all possible angles, considering what will give it the greatest meaning—the most facets and brilliance. And she is thorough—requesting ERIC searches, updating her materials, rewriting a section for greater clarity. She is truly not satisfied until convinced she has done all that can be done with a topic. A diamond cutter committed to perfection!

The second incident which reflects on Jane's capacity as an author is her openness to change—her willingness to adopt a new vision of the end product. When reviewing Jane's essentially completed manuscript, Gil Wrenn suggested that with certain "minor" revisions the book could be of great interest and usefulness to all adults with mature parents and anyone committed to helping older adults. Though it involved additional work at a time when her AACD Presidential responsibilities were growing, she unhesitatingly assumed the added writing tasks because she wanted to maximize the utility of the book. That describes Jane Myers—an author with a diamond cutter's commitment to optimizing the worth of a body of information "in the rough."

We believe she has succeeded in her task beyond all expectations. This monograph is thorough, succinct and eminently readable. Most of all, to use a favorite phrase of Jane's, it empowers the reader. Most likely you will wear your new knowledge from having read *Empowerment for Later Life* with pride and pleasure—just like you would a well cut diamond.

Garry R. Walz
Professor and Director, ERIC/CAPS

About the Author

Jane E. Myers is the 1990-91 President of the American Association for Counseling and Development and a Professor in the Department of Counseling and Specialized Educational Development at the University of North Carolina at Greensboro. Dr. Myers has worked as a rehabilitation counselor and administrator of aging programs for the state of Florida. In addition, she has directed five national projects on aging for AACD and has written and edited numerous publications, including 12 books and monographs. Dr. Myers has lectured and consulted nationally and internationally on the field of aging.

Among her numerous honors are the AACD Research Award, the AACD Arthur A. Hitchcock Distinguished Professional Service Award, and the Distinguished Service Award of both the National Rehabilitation Counseling Association and the American Rehabilitation Counseling Association.

Prologue

You really ought to meet my Aunt Perle: She is 76 years old, keeps a spotless home, cooks three meals a day for herself and her husband (Uncle Lee), bakes delicious pies for friends and neighbors (all from scratch), and provides meals and housekeeping assistance for an older widow (at no charge, of course). Though she has pretty much given up her lifelong Avon business, she still uses Avon products, visits the hairdresser weekly, "puts on her face" every morning, and once in a while, has a social drink. Aunt Perle is kind and generous, and she is aging with grace (whatever that means). Aunt Perle is just the kind of older person I would like to be someday.

Aunt Perle is kind and generous, and she is aging with grace. . . .

Aunt Perle's life has not been without challenges: A first marriage produced a son and daughter, but the daughter died of a brain tumor. Her second marriage to Uncle Lee has lasted 30 years; her only child from this union was killed his first week in Vietnam. Uncle Lee has been disabled for more than 25 years as a result of a degenerative muscle disease. He spent two years in a hospital and almost died. Aunt Perle has had seven major operations, including a heart by-pass. She wears glasses and a hearing aid and walks with a limp. Let me tell you about the limp.

Aunt Perle has had seven major operations, including a heart by-pass.

For her 70th birthday, Aunt Perle's son Bob took her and Uncle Lee to Reno for the weekend. Bob paid for a room at a major hotel, treated them to dinner, and bought tickets for a late show at the casino. The usher at the casino escorted them down a series of platforms to their seats. Somehow, when the usher turned around and bent over, he bumped Aunt Perle with sufficient force to send her 100 pounds crashing onto the floor of the level below. She knew instantly that her hip was broken and asked that no one move her. Another patron was heard exclaiming loudly, "Look at that drunk old woman!"

Another patron was heard exclaiming loudly, "Look at that drunk old woman!"

Well, the show had to go on, so the usher threw her over his shoulder and removed her from the show area. Bob and Uncle Lee took her to the local hospital where immediate surgery was recommended. Aunt Perle explained to the doctor at the hospital that her husband was disabled, they were living on a small, fixed income, and it would be much better for them if she could have the surgery and convalesce in her hometown.

The doctor became angry because she refused to have surgery. . . .

The doctor became angry because she refused to have surgery and he did not provide her with pain medication. They ended up paying $800.00 for an ambulance to drive her the three hours to their hometown. The medical technicians were not able to give her pain medication because the doctor had not ordered it. Her own doctor met them at the hospital and operated immediately.

If this story does not enrage you, then you will find little of value in the pages ahead.

If this story does not enrage you, then you will find little of value in the pages ahead. Aunt Perle's experiences with the usher and the doctor in Reno were not isolated incidents. Talk with a variety of older persons and you will learn how typical Aunt Perle's experiences were. If the indignities endured by an individual who also happens to be older arouse some feelings of discomfort, then you may find the information in this monograph beneficial. *Empowerment for Later Life* is not just for **those old people**—it is for all of us, and for our individual and collective future.

Jane E. Myers

Introduction

> **arbitrary**–adj. 1. not fixed by rules but left to one's choice, discretionary. 2. based on one's preference, notion, or whim; 3. absolute, despotic. (*Webster's New World Dictionary*, 1980, p. 70)

Why would a book on empowerment begin with a definition of "arbitrary" rather than a definition of "empowerment?" Is there a relationship between the two terms? The answer is yes. An early version of Roget's *Thesaurus* (undated) provides additional clues concerning this relationship, since many of the terms used to define **arbitrary** are the same ones used to describe **arbitrary power**, including the following:

> assume, usurp, take liberties, domineer, tyrannize, oppress...and in a manner that is stern, uncompromising, inflexible, relentless, **arbitrary**. (p. 276)

Children commonly are viewed as needing to grow, develop skills, learn, and take risks, and they are encouraged to do so. Young adults are encouraged to seek their fortune and to establish themselves in careers and relationships. Adults in mid-life are encouraged to devote their time to childrearing, to self-improvement, to career advancement and stabilization. What challenges to growth are faced by the older population? And, more importantly in our society, what encouragement is provided for continued growth, for continued risk taking?

What challenges to growth are faced by the older population?

A central concern in examining this question is that of arbitrariness. The arbitrary notions, preferences, and whims of society have the potential to usurp, oppress, and take away the liberties of older persons. To a very great extent, and usually without stopping to consider the antecedents or consequences, we limit the behaviors of older individuals based on the very arbitrary criterion of chronological age.

. . . we limit the behaviors of older individuals based on the very arbitrary criterion of chronological age.

Robert N. Butler (1975), in his award winning book *Why Survive? Being Old in America,* noted that old age is the

> neglected stepchild of the human life cycle....it is easier to manage the problem of death than the problem of living as an old person. Death is a dramatic, one-time crisis while old age is a day-by-day and year-by-year confrontation with powerful external and internal forces, a bittersweet coming to terms with one's own personality and life. (p. 1)

These internal and external forces are the subject of this book. Even more so are the processes by which professional helpers, agencies, institutions, family members, and friends can assist older persons in making these forces function in a positive, enabling manner to improve and enhance the quality of their lives. In this context, **empowerment may be defined as "nurturing belief in capability and competence"** (Ashcroft, 1987, pp. 144–145). Empowerment may be enhanced by any number of persons or groups. Alternately, any persons or groups may function individually or collectively to *reduce* a perceived sense of power. **The ultimate goal of empowerment efforts is to enable persons to live in a manner which maximizes their ability to develop positive, satisfying lifestyles.**

Empowerment may be enhanced by any number of persons or groups.

In the first chapter, the need for empowerment of older persons is examined, based first on demographic and social factors leading to a loss of power, and then on issues related to the quality of later life. The concept of empowerment is introduced and defined as a means of promoting positive mental health through enhancing self-efficacy in later life. The concept of empowerment is explored in greater detail in the second chapter. Included are a review of definitions and relevant research on this topic.

The third chapter provides a review of developmental issues important to understanding older persons and the aging process. An alternate model which focuses on life events or transitions is described as an explanation of adult behavior. A six-component wellness model is presented as another means of understanding late life functioning. This information provides a foundation for understanding social breakdown theory, which is described in Chapter 4. Also discussed are the implications of devalued status for psychological functioning in later life.

Chapter 5 presents a discussion of models and strategies for empowerment of older persons through remediation, while Chapter 6 includes a discussion of strategies for empowerment through a holistic wellness model. The final chapter reviews the need for developing and promoting empowerment throughout society as a means of enhancing the quality of life in the later years. Selected ERIC abstracts related to the topics covered in the first seven chapters are included in the final section.

While older persons are the focus of this discussion, it is clear that the concept of empowerment is equally applicable to any one experiencing a devalued status. There are many persons of all ages in our society who experience a lack of power as a result of the arbitrary definitions and actions of others. The reader may wish to apply the concepts presented here to other populations and circumstances.

. . . the concept of empowerment is equally applicable to any one experiencing devalued status.

Chapter 1

Aging and the Need for Empowerment

The need for empowerment of older persons is not necessarily self-evident. For the purposes of this discussion, such a pervasive need of the older population is assumed. In this chapter, some of the reasons underlying the need for empowerment are discussed. First, the nature and changing needs of the aging population are examined. Both demographic and social changes affecting the status of older people are considered. A possible link between the aging process and feelings of self-efficacy is explored. It is this link which most directly suggests a need for empowerment of older persons.

Demographic Changes, Personal Responses

The fact that our population is aging is no longer shocking.

The "graying of America," popularized by the media in the 1970s and 1980s, was accompanied by an increasing call for a societal response. The fact that our population is aging is no longer shocking. The need for change is evident; however, change that is slow in coming. For example, Florida, as a microcosm of the American population-to-come in the next 30 years, is viewed by many as the place that should be a national focus for model programs, services, and studies. Yet, researchers and policy makers in Florida lament the lack of available funds and political priorities which inhibit the growth of research and services

As a society, the phenomenon of aging is still "new," not fully understood, and easy to "put on the shelf."

for older persons. As a society, the phenomenon of aging is still "new," not fully understood, and easy to "put on the shelf."

We are nearing the end of a century. Within the past 100 years there have been more changes, technological and otherwise, than in the prior recorded history of the human species. As a result, persons who are older today have been called "survivors" and are to be respected for having lived through and adapted to an incredible array of changes. Examples of these changes include the advent of telephones (cellular and otherwise), televisions, microwave ovens, microcomputers, frozen dinners, airline travel, super highways, and more.

Another change is simply in the number of years they have lived. It is not at all uncommon to talk with older persons who have lived longer than any of their relatives. I have one older friend who often states "I didn't expect to live this long. I really shouldn't be around." Meanwhile she lacks familial role models for being "so old," and is basically uninvolved with life. Like many other older persons in similar circumstances, she has long since achieved her life goals and is waiting to see what will happen next.

As we approach the year 2000, people can expect to live into their late 80s....

In 1900, the average lifespan was 47. People could expect to grow up, marry, raise children and enter the post-parental era: their lifespan was essentially complete. As we approach the year 2000, people can expect to live into their late 80s, almost twice the lifespan of 100 years ago. Now when adults approach the "empty nest," they can expect to live another lifetime that lasts as long as the life they have already lived. Midlife has become a turning point, a time for reexamination and reevaluation of how life is lived, what it means, and what it **can** mean. Neugarten (1986) identified the existence of a shift in time perspective during mid-life which initiates the midlife transition. Rather than viewing life as time lived since birth, persons in midlife begin to see their lives as time remaining until death. Life now is seen as finite, and setting goals for the use of one's remaining time becomes increasingly important.

For many persons, the change in time perspective is accompanied by the onset of a crisis. The goals and dreams of youth may not have been realized. Viewing another lifetime ahead means that it may be time for a second chance. At the same time, changes and declines in physical stamina and prowess, the aging of one's parents, peaking of career paths, and other common midlife phenomena combine to create the perception that significant changes *can* occur, but *only* if one acts immediately, before it is too late. Important life decisions are perceived as "now-or-never" choices. It has to be now, while the vigor and determination of youth provide the energy and resources for change. The changes which are commonly made—career, spouse, lifestyle—and the setting of new goals have a significant impact on later life.

Viewing another lifetime ahead means that it may be time for a second chance.

Gender and Aging: Lifespan, Marriage, Income, and Social Supports

Increases in the lifespan are not uniform and are influenced by a number of factors. The most important of these is heredity, in that those who live longest are those who have chosen their ancestors carefully! Longevity seems to have a pervasive genetic component. The other major factor in longevity is lifestyle choices. Although there are exceptions, as with any rule, persons who live longer are those who manifest a concern for healthy lifestyles. Factors such as eating breakfast, not eating between meals, eating a balanced diet high in fiber and low in saturated fat, exercising moderately, obtaining regular and restful sleep, and obtaining periodic health screenings are correlated with increased longevity. On the other hand, diets high in saturated fats, smoking, sedentary habits, stress, and excess alcohol consumption have been correlated with increased mortality (Ferrini & Ferrini, 1986).

...persons who live longer are those who manifest a concern for healthy lifestyles.

There are noteworthy differences in the lifespan for men and women, with women living four or more years longer based on expected lifespan at birth. Due to a variety of survivorship factors, the longer people live, the longer they may expect to live. Women and men born in the late 1980s have a life expectancy at birth of 77 and 73 years, respectively. Those turning 60 in the 1980s have life expectancies of 84 and 80, respectively. Since women increasingly outlive men, as women age there are fewer and fewer males in the population. Sex ratios for women to men range from 122:100 for those aged 65–70 to 251:100 for those 85 and over (Butler & Lewis, 1983).

...as women age there are fewer and fewer males in the population.

The fact that women live longer than men, combined with the tendency for women to marry older men, result in more years of widowhood for older women. It is almost a societal norm that older women may expect to live at least the last 10–12 years of their lives alone. For many women it is much longer. Data from the 1980 census revealed that the average American woman can expect to be a widow for 25 years (Special Committee on Aging, 1983). This represents one-third or more of an older woman's lifetime. The American dream remains the same: grow up, marry, raise a family, live happily ever after. This dream is a myth for most persons today, especially for those older women spending unanticipated time in late life as single persons. For many older women, the day they lose their spouse to death is the beginning of living alone for the first time in their entire life. Unprepared for this occurrence, a variety of maladaptive or crisis reactions may occur. More will be said about this in later chapters.

For many older women, the day they lose their spouse to death is the beginning of living alone for the first time in their entire life.

Divorce in middle and later life is another factor creating single status for many older women. Today more than 77% of older men (over age 65) are married, while only 40% of older women (over age 65) are married. While 51% of older women are widowed, only 14% of older men are widowed. When older men lose a spouse through death or divorce, they tend to remarry. Older women tend to remain single. A related fact is that 82% of older men live in family environments compared to only 57% of older women (American Association of Retired Persons [AARP], 1987). Most older women live alone.

Most older women live alone.

About one in five older persons are poor, with most of these being older women. The overall poverty rate in America is 13%, while among older persons it is 16%. The latter includes 8% of white males, 17% of white females, 33% of Black males, and 49% of Black females (AARP, 1987). The problems of aging, not surprisingly, are often described as the problems of women, particularly minority females. Being old is defined in our society as being in jeopardy, or in danger. Given this definition, being old and female places one in a position of double jeopardy. Clearly, older minority females face at least a triple jeopardy situation—being old, female, and a minority group member.

Being old is defined in our society as being in jeopardy, or in danger.

A final gender difference is found in the social support network of older people. Since older women tend to live alone, they also are over-represented in long-term care settings. Older men in need of care typically can call on family members for support, while older women are more likely to need social and community services. Adult children providing care for aging parents most likely will provide that care for mothers. Older men tend to receive needed care from a younger spouse.

...older women are more likely to need social and community services.

In looking at gender differences, older women are clearly a population at risk. Today's older women are less independent than the older women of the future, having been raised in a time when motherhood, childrearing, and homemaking were the normative social roles for women. Younger women increasingly are entering careers, while many of today's older women have never worked. Among those who have been employed, lower status jobs (hence, lower retirement incomes) are common. Many of today's older women lack skills in assertive behaviors, having been taught that appropriate female behavior is to be submissive and conciliatory. Thus, lacking a strong history of independence, many of today's older women are experiencing the cumulative impact of a lifetime of events which combine to create a lack of empowerment in dealing with the circumstances of later life.

> One of the author's widowed friends did not learn to drive until her husband of 40 years died suddenly of a heart attack. Another widowed friend had never managed her own checkbook. After her husband's death, she struggled with financial matters for a few years, then finally turned over her accounts and responsibility for writing all checks to a bank trust. Though the bank fees bothered her at first, the freedom from worry about having her bills paid made this a desirable option. An added benefit for her was the ability to have someone else say "no" to purchases of items she may not have actually needed. On one occasion she had succumbed to an insurance salesperson and was paying more than $350 a month for two nursing home insurance policies which essentially duplicated her existing health benefits through medicaid, medicare, and a private policy. When questioned about the purchases, she could only respond that the agent was *so* nice, and *so* insistent, and *maybe* she would need the policies someday....the next year she dropped both policies and five years later is not in a situation where she might need them.

Lack of assertive behaviors, lack of experience with financial matters, and fear about the future made this woman, like many older women, an easy target for misrepresentation and fraud.

...86% of the older population experience one or more chronic physical impairments which limit their daily living activities.

Health, Disability, and Aging

While 80% of older persons report their health to be excellent or good (Harris & Associates, 1981), it is still true that 86% of the older population experience one or more chronic physical impairments which limit their daily living activities (Brotman, 1982). The most common impairments are progressive, with changes in functioning and health status being gradual and occurring over many years. Most changes occur so slowly that people are able to cope and adapt with little conscious effort. One difference between older and younger persons is the presence of multiple functional changes and losses. Since changes and declines occur with age in all body systems, the cumulative effect of these changes is what becomes evident, disabling, and sometimes simply overwhelming.

The most common health problems reported by older persons are arthritis (44%), hypertension (39%), hearing impairments (28%), heart disease (27%), arteriosclerosis (21%), visual impairment (12%), and diabetes (8%) (Brotman, 1982). These conditions all are responsible for progressive disabilities sometimes resulting in death. The three leading causes of death—heart disease, stroke, and cancer—together account for more than three-fourths of all deaths among older persons. Each of these conditions is greatly affected by lifestyle choices, particularly long-term choices related to exercise and diet.

Related to the incidence of physical disorders is the consumption of health care services among the older population. Older persons comprise only 12% of the population yet use over 40% of all prescription drugs. The common, chronic physical problems of later life tend to require continuing medical care. Older persons visit physicians more often and have more and longer hospital stays than younger persons. Physicians estimate that 80% of health care dollars are spent in the last six months of life. The fact that so many older persons are so often subjected to the medical model for treatment has significant implications for empowerment issues. These implications are discussed further in Chapter 3. The section which follows provides support for another perspective on the need for empowerment of the older population.

Older persons comprise only 12% of the population yet use over 40% of all prescription drugs.

The Social Context of Aging

Numerous myths... perpetuate a view of aging as unpleasant, sad, depressing, or worse.

Aging occurs in a social context, and reactions to personal aging are affected greatly by societal attitudes. In general, attitudes toward older persons are negative. Numerous myths and misconceptions exist which perpetuate a view of aging as unpleasant, sad, depressing, or worse. The term "ageism" was coined by Butler (1975) to describe the prevalent societal perception of older persons. Similar to racism and sexism, ageism categorizes and views negatively those 25,500,000 persons who happen to be above the arbitrary age limit of 65. Younger persons who happen to **look** or **act** older are viewed similarly.

...the public in general maintains a negative view of the aging process and aged persons.

Several aspects of ageism are noteworthy. The first is that the public in general maintains a negative view of the aging process and aged persons. Among the common myths about older persons are the perceptions that they are all alike, all poor, all sick, all depressed, all living alone or in institutions, all senile, and most generally unable to function in society. Although only 5% of older persons reside in long-term care settings, these persons comprise the most disabled and frail persons among the older population. Since debilitation and disability are so highly feared, the characteristics (frail and dependent) of a small minority of the older population are **spread** in the minds of others, and assumed by many to be the characteristics of **all** older persons.

Wright (1960) defined the phenomenon of **spread** as the tendency to attribute multiple characteristics to an individual or group based on one salient aspect such as a disability. Even a minor visible disability may cause non-disabled persons to react to a disabled individual with stereotypical responses. Similarly, the fact that someone is old may cause others to see that person in stereotypical ways typically ascribed to those who are old—poor, slow, sick, etc. This phenomenon of **spread** may operate to convince even older persons themselves of the lack of worth of other persons who are older, thus inhibiting the establishment of satisfying peer relationships. It is not uncommon to hear older persons refer to other older persons as "boring."

Similarly, it is common for older people to view one another differently based on age. With 60 as the federal criterion for "old age," the later years can span some 40 or more years. The first 40 years of life are a time of much diversity. It has been said that as people grow older they become more and more like themselves and less and less like anyone else. There are many differences which **could** be expected in the older population, or indeed any group of more than 25 million persons. Some of these differences, such as the presence of wrinkles or gray hair, could be related to age. Others may be due to **perceptions** of age, such as the stereotypes that older persons are slow, frail, or sexless.

It is not uncommon to hear older persons refer to other older persons as "boring."

...as people grow older they become more and more like themselves and less and less like anyone else.

Two examples of how some older persons view other older persons may help to clarify this point. The author once employed three part-time secretaries, ages 60, 64, and 68. It was hard not to chuckle out loud when listening to the two younger ones talk about their "old" colleague. Clearly, they did not view her as a contemporary. "You know," said one, "at her age she just shouldn't be doing that!" The other nodded her head in complete agreement. On another occasion, the author was discussing the cold Northern climate with an older friend. The friend explained that two mutual friends, aged 86 and 87, would not be joining her at a meeting because "they could not take the bitter cold." I mistakenly commented that I did not see how she, at age 68, could tolerate the climate either. After all, she had no automobile and frequently walked for groceries as well as to the subway station. I realized she was offended at my comparison of her and them as "older persons," when she emphatically proclaimed, "well, **I'm not as old as they are!**"

A second aspect of ageism relates to the self-concept of older individuals. It is natural for persons living in a society to come to believe what are commonly perceived as societal truths, even if those truths are easily exposed as myths. Hence, it is not uncommon for older persons themselves to internalize the view that old people are poor, sick, disabled, depressed, and so forth. Since aging is viewed as undesirable, as persons become older they may experience difficulty in accepting themselves as they are.

...it is not uncommon for older persons... to internalize the view that old people are poor, sick, disabled....

The acceptance of oneself as an aged person, which commonly connotes someone of devalued status, may be accompanied by a loss of feelings of self-esteem. Further, the expectation that one will become sad or sick may become self-fulfilling. Many older people have been heard to say that "old age is a terrible thing!" For them, it probably is. On the other hand, denial of aging in someone who has lived 60, 70, or 80 years may be a distortion of self-concept. Among the possible outcomes of this denial would be an inhibition of the successful resolution of major developmental tasks. However, some evidence suggests that older persons who refuse to identify themselves as "old," with all the negative connotations such self-identification entails, are healthier and more satisfied with their lives (Barbato & Feezel, 1987). For better or worse, the mental health of older persons is affected by their perceptions of age and aging for themselves and others.

...denial of aging in someone who has lived 60, 70, or 80 years may be a distortion of self-concept.

It is common for older people to report that they see themselves as they were when they were younger. Some report that their bodies are old, but that they do not *feel* old.

> A retired friend reported on an interesting incident which occurred when she was caring for her mother. As they walked past a mirror, the mother stopped and pointed and said "who's that?" "Why, Mama, that's you and me," said the daughter. "No," her mother replied emphatically, "who's that *old* person?"

A third consideration is the effect of widespread ageist attitudes on society and social institutions. The

United States does not now have a national policy on older workers, yet we have a national policy on retirement. That retirement policy was first implemented in 1935, when the newly formed Social Security Administration defined **old age** as beginning at 65. The exception which has held until the present is that persons who become **disabled** may meet the criteria for "old" as early as age 62. Until the 1980s, mandatory retirement policies have required retirement, even of able-bodied and capable older workers, at the arbitrary age of 65. Examining the origins of the arbitrary nature of the age criterion is interesting: The United States modeled the age-65 retirement on Bismarck's Germany. What is clear from a review of the demographic data provided earlier in this chapter is that few persons lived to or into their retirement years at the time the policy was set. As persons have lived longer, the financial strain on our Social Security system has become evident. Hence, the raising of the retirement age, for financial as well as humane reasons, has not been surprising.

The United States does not now have a national policy on older workers, yet we have a national policy on retirement.

As persons have lived longer, the financial strain on our Social Security system has become evident.

Ageist prejudices and biases represent additional concerns for older persons. Based on the arbitrary criterion of chronological age, older persons are told to "act your age!" or "you can't do that at your age!" Such statements come from relatives, neighbors, and friends, as well as society at large. Age prejudices dictate how older persons should dress, the recreation and leisure pursuits they pursue, the nature of their romantic involvements, and their expressions of sexuality. Younger men who whistle at attractive women may be termed womanizers or flirts. Older men who engage in the same behavior are labeled "dirty old men."

Arbitrary age criteria are used to delimit social and personal privileges of various individuals, most especially those who are older. Younger persons face age criteria for freedoms such as the right to drive a car, or the right to purchase alcoholic beverages. Older persons face age criteria which restrict their freedoms, such as mandatory retirement, inability to purchase insurance, or restricted employment opportunities.

It is no accident that the *Age Discrimination in Employment Act* was passed to protect older persons seeking gainful work opportunities. Employers commonly hire younger workers over older applicants, since employers are affected by the negative stereotypes which classify older workers as insurance liabilities who are slow, accident prone, and often absent from the job. What is surprising is that the arbitrary age definition of older workers begins at the midlife age of 40! The American Association for Retired Persons has opened eligibility for membership to persons beginning at age 50 prompted by increasing numbers of younger retirees, a decrease of five years from the original age of 55. Many airlines are offering special fares to persons age 60 and above, yet an existing federal law still requires mandatory retirement of airline pilots at the age of 60.

Employers commonly hire younger workers over older applicants....

The midlife period of life and "old age" seem to be blending at an earlier age. Midlife has been variously defined as beginning at age 35 or 40 and ending at age 55, 60, or 65. Most old persons will define themselves as in midlife, at least until they experience significant physical decline; then they will become "old." People in midlife in our society have been called the "command generation." They occupy more positions of power and prestige than persons of any other age group. Such power is not easily surrendered based on an arbitrary criterion such as chronological age.

We seem to be entering an era when attitudes toward older persons are changing.

We seem to be entering an era when attitudes toward older persons are changing. Yet, negative attitudes exist and are pervasive, and adversely affect the freedoms of many of our older citizens. Again, many of these attitudes are based on myths, misconceptions, and arbitrary definitions. The effect is to devalue older people, and thus to erode the use of personal power they experienced through most of their lives. This erosion of power, combined with the personal losses which many older persons experience, can have significant negative effects on the emotional and mental health of older individuals. Such effects are discussed in more detail in Chapter 4. Noteworthy here is the potential for good mental health in the later years, a potential which can be maximized through empowerment.

The Need for Empowerment

One of the obvious conclusions from the preceding discussion is that increases in the quality of life have not kept pace with increases in the quantity of life. People are living longer, but not necessarily with a greater sense of satisfaction and enjoyment of life.

...increases in the quality of life have not kept pace with increases in the quantity of life.

Life satisfaction has been studied extensively as a major predictor of the mental health of older persons. It is defined as a feeling of high morale or contentment, and is accompanied by a sense of well-being. Persons who are satisfied with their lives maintain a sense of dignity and are able to accomplish the goal specified in the *Desiderata* (1972), that of growing old gracefully.

Correlates of satisfaction in the later years include the presence of a spouse, children, and other social supports, adequate income, good physical and emotional health, adequate housing and transportation, and independence. Even in the absence of objective evidence of a quality lifestyle, the available evidence indicates that it is often **attitude** which determines satisfaction with one's life.

...it is often attitude which determines satisfaction with one's life.

Two of the most commonly used indices of life satisfaction are self-concept and locus of control. Self-concept refers to feelings of self-worth or self-esteem. Locus of control refers to a perception of events as either under one's personal control (internal) or as the result of circumstances over which one may have no control (external).

The most satisfied people tend to be those who feel independent, and who believe they have control over the circumstances of their lives. These people are also capable of meeting their goals, and experience a sense of **self-efficacy** (they believe they have power over their lives). This feeling of being in control is accompanied by a positive sense of self-esteem and self-worth, and also may be defined as having or feeling a sense of personal power. Those persons who do not experience a sense of self-efficacy or a belief in their own personal power to control their lives, then, are in need of empowerment. To take this one step further, we may conclude that **empowerment** can be an effective, possibly necessary, strategy for enhancing feelings of self-efficacy. Such feelings will be accompanied by an increased sense of self-worth and an internal locus of control, thus contributing to life satisfaction in the later years.

This feeling of being in control is accompanied by a positive sense of self-esteem and self-worth....

Chapter 2

Self-Efficacy and Empowerment

The concept of empowerment has gained attention in the past two decades as an explanation of both individual and societal reactions to disadvantagement and the need for change. The concept of self-efficacy mentioned in Chapter 1 is important in understanding empowerment. In this chapter, self-efficacy is discussed, definitions of empowerment are reviewed, and models of helping are used to provide a context for the empowerment process.

Self-Efficacy and Behavior

Bandura (1977, 1982) proposed the concept of self-efficacy as an explanation of behavior and behavior change. People's beliefs or expectations about their ability to perform a particular behavior, or self-perceptions of efficacy, influence their thought patterns, actions, and emotions. People tend to avoid activities they believe exceed their coping abilities and undertake those they consider themselves capable of handling. Efficacy expectations influence the decision to attempt a behavior, the length of time it will be attempted, and the effort which will be involved. Low efficacy expectations in the face of obstacles will result in persons experiencing serious doubts or giving up, while high efficacy expectations will result in greater efforts being exerted to achieve desired results.

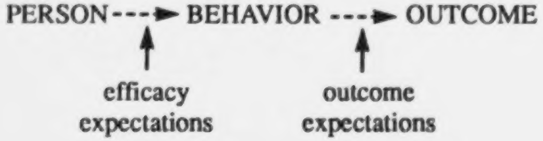
People tend to avoid activities they believe exceed their coping abilities....

This explains how people with objectively similar resources and opportunities can react quite differently to even minimally challenging situations. Some older widows are active in church or civic activities, social groups and affairs, or travel. Others of similar age, life circumstances, and resources are largely isolated and uninvolved with life. The active widows experience high self-efficacy.

Persons with low self-efficacy expectations may not attempt certain behavior at all....

Persons with low self-efficacy expectations may not attempt certain behavior at all, even if the result of that behavior would be a desired outcome. Such persons experience high levels of anxiety, view challenging situations as threatening, and dwell on their deficiencies. For example, persons who would like to learn a new subject but consider themselves unable to perform successfully in an academic environment, may choose not to enroll in classes they would like to take. At the same time, they may lament their inability to learn the subject, using their perceived inability to justify the lack of trying. Persons with high self-efficacy expectations tend to explore options freely, experience less anxiety, and are able to successfully implement and change behavior to achieve desired outcomes (Borders & Archadel, 1987). Even though they may have difficulty learning a new subject, persons with high self-efficacy expectations will enroll in courses and apply themselves for extended periods in difficult learning situations. They believe that they will ultimately succeed, thus their efforts will be rewarded and are perceived by them as worthwhile.

The theoretical framework for self-efficacy involves two key concepts (Bandura, 1977). The first concept is that the likelihood of a person engaging in a behavior is related to their efficacy expectations, or to their perceptions that they can engage in or execute a particular behavior. The second concept is the expectation that a desired outcome that will result from a particular behavior affects whether one chooses to engage in it. These two aspects of efficacy act in concert and are interactive. Bandura (1977) diagrammed this relationship as follows:



According to this model, if a woman (PERSON) is to change her diet to lose weight (BEHAVIOR) for health reasons (OUTCOME), she must believe that the weight loss will benefit her health (OUTCOME EXPECTATION) and that she is capable of losing the weight (EFFICACY EXPECTATION).

If a man (PERSON) is to change his lifestyle habits (BEHAVIOR) to lower his cholesterol level and thus reduce the risk of a heart attack (OUTCOME), he must believe that the change in lifestyle will result in a reduced chance of heart disease (OUTCOME EXPECTATION) and that he is capable of successfully implementing the changes in his life (EFFICACY EXPECTATION).

If an older woman (PERSON) is to actively seek employment (BEHAVIOR) to gain additional income (OUTCOME), she must believe that seeking employment will result in obtaining a job (OUTCOME EXPECTATION) and that she will be able to perform the job effectively and satisfactorily (EFFICACY EXPECTATION).

As defined here, the concept of efficacy is related to that of locus of control. Persons with an internal locus of control generally view themselves as controlling their own behavior. Those with an external locus of control view external forces as responsible for the circumstances and events in their lives. Persons with an internal locus of control also have a high sense of self-efficacy in that they believe their actions will achieve desired outcomes.

Persons with an internal locus of control generally view themselves as controlling their own behavior.

Efficacy expectations are learned from four major sources (Strecher, DeVellis, Becker, & Rosenstock, 1986). The first and most powerful source is through performance accomplishments. These are personal experiences in which one achieves mastery over a difficult task and thus experiences a sense of self-efficacy. One learns that one is capable, and that one's efforts will be rewarded.

One learns that one is capable, and that one's efforts will be rewarded.

The second source is through vicarious experience, or learning through observations of other persons and events which serve as models of behavior. Modeled behaviors must be presented so that the model is perceived as achieving success through personal effort rather than with ease or luck. The model also must be similar in characteristics to the observer to have a positive effect on self-efficacy. Both live and symbolic modeling may be used. Modeling can be effective with older persons living in congregate settings, where both observation and "peer pressure" can be motivations to try new behaviors.

The third source of efficacy expectations is verbal persuasion, particularly by an "expert." This could include suggestion, exhortation, self-instruction, and so forth. The medical model can be effective in this regard. Persons who are respected, as physicians are by most older persons, can use verbal persuasion to have a persuasive influence on the behavior and self-efficacy of those who look up to them. The author's mother, for example, was repeatedly asked by her daughters to quit smoking. Her standard reply was "Dr. Smith knows I smoke. If he thought it was bad for me, he'd tell me to quit." One day he actually told her to quit—and she did!

Another means of verbal persuasion is through encouragement, which is discussed in Chapter 6. As defined by Sweeney (1989), encouragement "inspires or helps others toward a conviction that they can work on finding solutions and that they can cope with any predicament" (p. 108). Dinkmeyer and Losoncy (1980) defined encouragement as "the process whereby one focuses on the individual's resources in order to build that person's self-esteem, self-confidence, and feelings of worth" (p. 65).

Physiological arousal is the fourth source of efficacy expectations. Over-arousal, or extreme stress reactions, typically impair performance and lead to expectations of failure. Some level of stress, recognized as such, is an important motivation for behavior change. Self-efficacy enhancing strategies which incorporate physiological awareness include relaxation and biofeedback strategies which are largely unfamiliar to older persons today and need to be taught slowly and with ample time for demonstration and discussion.

...extreme stress reactions, typically impair performance and lead to expectations of failure.

One noteworthy difference between older and younger persons today is the popularity of self-help books, articles, and tapes, and the acceptability of receiving counseling and other mental health services, that has made younger people much more open to and knowledgeable about their own feelings and stress responses. Older persons, by contrast, lack a vocabulary for describing feelings and may be unaware of the sources of stress in their lives. In addition, they may lack coping resources for reducing the negative effects of multiple stressors. Strategies for coping which were effective in younger years may simply be unavailable (e.g., spouse is no longer available, as a result of death) or ineffective (e.g., assistance from adult children may be unavailable as they need to care for their own teenage children).

Older persons... lack a vocabulary for describing feelings and may be unaware of the sources of stress in their lives.

Bandura (1982) noted that the "inability to influence events and social conditions that significantly affect one's life can give rise to feelings of futility and despondency" (p. 140). He further noted two distinct sources of futility. On the one hand, people may give up because they doubt their ability to do what is required of them. On the other hand, people may be confident in their abilities but perceive that their efforts will be ineffective due to negative attitudes of others or unresponsive or punitive environments. Self-

...people may give up because they doubt their ability to do what is required of them.

efficacy judgments and outcome judgments thus are interactive in determining behavior. Four combinations are possible:

		Self-Efficacy	
		Low	High
Outcome Expectation	Low	3	2
	High	4	1

1. **Persons who have a high sense of self-efficacy and high outcome expectations (quadrant 1)** will act in a manner which reflects self-assurance. When the environment rewards their behaviors, they will continue to function independently and in a healthy manner. Older persons who live independently in the community, engage in satisfying leisure pursuits, and set and achieve new goals on a continuing basis are examples of persons in this quadrant of the chart. Older persons who choose to maintain control of their lives by anticipating a future time when their health may decline, and making present lifestyle choices based on their future needs, are additional examples. Such persons may move to a retirement or life care community while yet very healthy, thus allowing the development of new support networks while still very active and involved. They also are able to cope successfully with the emotional and physical strain of condensing a lifetime of expanding possessions into a necessary-but-sufficient combination of items to fill a small apartment.

2. **When high self-efficacy is combined with low expectations of successful outcomes (quadrant 2),** older persons may choose social activism and advocacy as a means of bringing about needed changes.

...older persons may choose social activism and advocacy as a means of bringing about needed changes.

The Gray Panthers, a political activist organization for older persons, is based on this combination. Change is perceived as needed, but only as possible with large scale efforts. These beliefs lead many older persons to pursue active roles in community politics.

3. **Persons with a low sense of self-efficacy, faced with low expectations of successful outcomes (quadrant 3),** will give up easily. They will likely become apathetic, believing themselves and the environment incapable of change. Older persons who believe themselves incapable of remaining active, due to their age and declining energy reserves, may find themselves spending more and more time at home alone. Lack of social contacts only serves to reinforce their belief that they are incapable of independence.

Persons with a low sense of self-efficacy... will give up easily.

4. **Those with a low sense of self-efficacy who are faced with high expectations of successful outcomes but do not achieve those outcomes (quadrant 4)** are likely to blame themselves. They may experience a shift from believing their efforts will go unrewarded to believing themselves incapable of performing. This is referred to as learned helplessness (Seligman, 1975). Older persons who view other older persons as active and healthy, but see themselves as not active, may experience decreased self-esteem as a result. As one older woman put it, "well, I guess these other old people don't feel as badly as I do. I'm just so pokey." On another occasion this same woman commented on how fortunate she was to have no arthritis, rheumatism, or other aches and pains. Clearly, this woman was more physically healthy than her age peers, but far less active as a result of her low sense of self-efficacy.

Many persons reach their later years with a high sense of self-efficacy and an internal locus of control. This sense is built on years of successful behaviors and effective actions resulting in desired consequences. One frequent concomitant of aging is multiple losses over which older persons may have little or no control, such as loss of friends and family members through

Many persons reach their later years with a high sense of self-efficacy and an internal locus of control.

geographic relocation or death, loss of jobs due to forced retirement, and loss of social roles. Such losses may cause older persons to question their capabilities, or their ability to influence their environment by their actions.

When people believe that they are capable, but consider that their abilities will not result in desired outcomes, an incongruity exists. This incongruity can be resolved by a change in the perception of one's capabilities or by a change in strategies (behaviors) to effect outcomes. Unfortunately, as will be seen in Chapter 4, older persons may react to perceptions of their own inability to change situations with a passive acceptance, a change from an internal to an external locus of control, and a sense of learned helplessness resulting in depression. Their expectations of self-efficacy may decline considerably.

On the other hand, changes in strategies or behaviors used to effect outcomes are possible at any age. Older persons can be taught and helped to implement new behavioral strategies, thus enhancing self-efficacy. Strategies for enhancing self-efficacy are discussed following a review of the concept of empowerment. From this discussion, the close connection between self-efficacy and empowerment will become even more apparent.

Older persons can be taught and helped to implement new behavioral strategies, thus enhancing self-efficacy.

Defining Empowerment

The concept of empowerment has emerged in the past two decades and has been variously defined. Most definitions share in common one or more of the following concepts (*Webster's New World Dictionary*, 1980):

> **power**—ability to do, capacity to act, capability of performing or producing...the ability to control others; authority; sway; influence.
>
> **empower**—to give power or authority to; authorize...to give ability to; enable; permit.

Empowerment enhances a sense of self-efficacy which enables a person to take action on his or her own behalf. Baker-Miller (1982) defined empowering as fostering growth in others, and Vanderslice (1984) defined empowerment as "a process through which people become more able to influence those people and organizations that effect their lives and the lives of those they care about" (p. 2). The process of empowerment may involve change in individuals and mediating structures (e.g., family, neighborhood, church) or organizations. A focus on individuals may lead to a state of isolation and leave persons relatively powerless in dealing with institutions (Zacharakis-Jutz, 1988). Thus, both individuals and society must be considered part of the empowerment process. Cochran (1987) summarized these issues by defining empowerment as:

...both individuals and society must be considered part of the empowerment process.

> an interactive process involving mutual respect and critical reflection through which both people and controlling institutions are changed in ways which provide those people with greater influence over individuals and institutions which are in some way impeding their efforts to achieve equal status in society, for themselves and those they care about. (p. 11)

An example may help to clarify this point. Persons with disabilities traditionally have been viewed from an individualistic perspective, at least in the United States. Not all disabilities result in handicaps which affect a person's optimum personal and social adjustment. Those persons with disabilities who do experience handicaps have been viewed as **responsible** for overcoming the limitations imposed by their disabilities. The individualistic perspective has often been linked with a view of the person with a disability as being **responsible** for their condition. Certain Judeo-Christian beliefs place the cause for personal distress on individual or familial behaviors. A person under the influence of alcohol who is injured in an automobile

Persons with disabilities traditionally have been viewed from an individualistic perspective.

accident may be seen as responsible for his or her disability as a result of the personal choice to drink and drive. Even in the case of accidental injury or birth defects, the person with a disability is viewed as needing to develop positive attitudes and a sense of self-efficacy which will result in his or her independence from society. Failure to make a successful adjustment to a disability is viewed, from the individualistic perspective, as a personal failure.

Failure to make a successful adjustment to a disability is viewed...as a personal failure.

In marked contrast to the individualistic view is the more recent perception of society as responsible for placing barriers in the way of optimal adjustment of disabled individuals (Stubbins, 1977). From this vantage point, it is the lack of accessible housing and public transportation, the lack of worksite modifications, and the negative attitudes of employers and society which are responsible for the difficulties experienced by persons with disabilities. Change must occur in social institutions if disabled individuals are to achieve their optimum level of adjustment.

...both individuals and institutions must change if true equality of opportunity is to be achieved.

It is probably valid to say that both individuals and institutions must change if true equality of opportunity is to be achieved. Thus, the process of empowerment must incorporate the needs of both individuals and institutions. Such needs are interactive. If people are to be empowered to experience a sense of self-efficacy leading to attempts to influence the circumstances of their lives, institutions must be empowered to incorporate active individuals as successful agents for institutional and societal change. The models of helping discussed below provide a framework for understanding the interaction between individuals and institutions in the empowerment process.

Models of Helping and Empowerment

Recent research on helping processes has resulted in the conclusion that receiving help can sometimes be more detrimental than receiving no help at all. The method through which help is provided may, in fact, be as significant as the help itself (Brickman, Rabinowitz, Karuza, Coates, Cohn, & Kidder, 1982). Empowerment is not a panacea for all individual and societal concerns—in some instances empowerment may even be counterproductive.

...in some instances empowerment may even be counter-productive.

Brickman et. al (1982) developed a typology of helping which is based on attributions of responsibility for problems and solutions. Responsibility for problems refers to who is to blame for past events, while responsibility for solutions refers to who is to control future events. Four models were proposed, with the admonition that different models may be more or less effective in different situations.

The first model is the **moral model**. In this model, individuals are responsible for their problems and also responsible for the solutions to those problems. Proper motivation is required for individuals to take action to resolve their concerns. The individualistic model of disability described above is an example of the moral model. Disabled individuals are viewed more or less as creating their own handicaps and needing to overcome those handicaps through personal effort.

The second model is the **enlightenment model**. From this perspective, people are held responsible for their problems but not for the solutions to those problems. They are viewed as being either unwilling or unable to provide their own solutions; thus people need outside intervention to assist them in achieving self-discipline. Some of the most successful treatment programs for alcohol and substance abuse, such as Alcoholics Anonymous, operate on the enlightenment model. People are seen as responsible for their addictive behaviors, but needing a strong outside source to assist them in rehabilitation.

The third model is the **medical model**. People are seen as needing treatment, but are responsible neither for their condition nor for the solution to their problems. Powerful others, "experts," diagnose their problems and prescribe treatment. A strong sense of self-efficacy can actually hinder progress in this model. What is required is that older persons submit to medical treatment regimes to cope successfully with problems they did not cause and cannot resolve on their own. Empowerment in the medical model will lead to conflicts between older persons and care providers.

The final model, the **compensatory model**, does not view people as being responsible for their problems. On the other hand, this model **does** consider persons to be responsible for the solutions to their problems. Empowerment to take action is what is required of them. Older persons may be viewed as limited by societal perceptions and ageist beliefs. They need empowerment to help them function independently and to change the attitudes and beliefs which restrict their freedoms.

Older persons may be viewed as limited by societal perceptions and ageist beliefs.

In comparing these models, it can be seen that neither the medical nor compensatory models blame individuals for their problems. The assumptions about who is responsible for effecting changes, however, is quite different. The medical model makes the assumption that experts should provide the treatment/solutions, while the compensatory model posits the involvement of individuals, families, and communities in resolving issues.

The medical model can lead to dependency, with others considered responsible for finding solutions.

Hughes (1987) noted that both models have the potential for adverse consequences. The medical model can lead to dependency, with others considered responsible for finding solutions. The compensatory model can lead to hostility and alienation as people are seen as needing to solve problems which were not of their making. Hughes further concluded that hostility is preferable to dependency, since the latter contributes to learned helplessness and a continuing cycle of inability to take action. The compensatory model offers the possibility of people being given credit for their solutions while not being blamed for their problems, thus contributing to a sense of self-efficacy in dealing with difficult circumstances and events.

A further conclusion from Hughes' (1987) research is that empowerment is the most appropriate strategy in the compensatory model for providing help. Building on Rappaport's (1981) definition of empowerment as an attempt to "enhance the possibilities for people to control their own lives" (p. 15), Hughes emphasizes the idea that empowerment is based on a non-deficit model. The assumption is that individuals, families, and communities possess strengths which can be mobilized in their own behalf. Related assumptions are that: (1) people have valuable knowledge of their own needs and goals, (2) divergent thinking, incorporating ideas from multiple sources, is helpful in problem solving, and (3) help is most effective when provided through intimate social institutions, such as family, friends, and neighborhoods.

The assumption is that individuals, families, and communities possess strengths which can be mobilized in their own behalf.

Eligibility requirements for services which require persons to demonstrate a weakness or deficit in order to get help would be antithetical in the compensatory model. Such requirements are common to most social services entitlement programs and to programs provided through a medical model. On the other hand, severely dysfunctional families or incapacitated communities may best be served by a medical model rather than an empowerment approach. Again, the key point is to choose the model to meet the needs of individuals. Empowerment can be useful in many instances, but used inappropriately, this strategy could be harmful.

Hughes (1987) summarized four primary assumptions on which the empowerment process is based. These assumptions are suggestive of strategies for implementing empowerment efforts. They include:

1. recognizing and fostering strengths and competencies;
2. acknowledging and utilizing the wisdom of everyday experience;
3. promoting diversity of ideas and approaches; and

4. strengthening social networks and community institutions. (p. 398)

...the empowerment process would involve (1) assessment of competencies, (2) encouragement of self-esteem and self-efficacy....

As defined in these four assumptions, the empowerment process would involve (1)assessment of competencies, (2) encouragement of self-esteem and self-efficacy, (3) involvement of individuals and groups in assessing needs and setting goals and priorities, (4) use of the individual and collective expertise of these individuals and groups, and (5) efforts aimed at building and enhancing linkages and social networks. Kindervatter (1979) further suggested several indicators of successful outcomes of the empowerment process. These include:

- increased access to resources;
- increased collective bargaining power; improved status, self-esteem, and cultural identity;
- the ability to reflect critically and solve problems;
- the ability to make choices;
- the legitimation of people's demands by officials; and
- self-discipline and the ability to work with others. (p. 234)

Such outcomes could be important in helping older persons achieve life satisfaction and a sense of control over their environment and the circumstances of their lives. These circumstances form the basis for application of empowerment strategies with older persons. They include common aspects of growth and development in later life as well as barriers to optimal growth in the later years. These factors are discussed in Chapter 3.

Chapter 3

Developmental and Transition Theories for Later Life

One of the major assumptions underlying the empowerment process, as described in Chapter 2, is the need to recognize and foster strengths and competencies of older persons. These strengths can be identified in part through an examination of late life development. In addition, Cochran (1987) emphasized that

> empowerment **only** [author's emphasis] becomes germane to the developing individual when barriers to the normal course of development are encountered, the removal of which are beyond the present or future capacity of that person as an individual. These obstacles are the raison d'etre of the empowerment process, and therefore progress in overcoming them must be seen as the basic purpose underlying that process. (p. 11)

Developmental theories discussed in this chapter provide a framework for viewing the challenges and growth potential of the later years. Transition theories provide an alternate model for viewing late life adaptation. Following a discussion of each type of theory, a multifaceted wellness model is described as a holistic framework for viewing functioning of older persons.

One of the major assumptions underlying the empowerment process...is the need to recognize and foster strengths and competencies of older persons.

Theoretical Perspectives on Development in Later Life

Most people live between two-thirds and three-fourths of their lives as adults, with one-fourth to one-third as older adults. Although not all important events occur during childhood, relatively little is known about adult development in comparison to the childhood and adolescent years. Van Hoose and Worth (1982) noted that "adulthood is a time of continuing development and change that often leads to the discovery of new potential and enriched lives" (p. 5). Gould (1980) further observed that both object (non-biological) and biological changes occur throughout the lifespan, with object changes being even more dramatic after the age of 21 than before age 21.

...relatively little is known about adult development....

In contrast to child and adolescent development, the major milestones of adulthood are described in terms of psychological considerations, rather than physical maturation, legal entitlement, or chronological age. This is not to say that physical changes do not occur in adulthood, since they do. Visual declines, decreases in muscular strength and stamina, and other common physical changes have been shown to be related to age. However, there is tremendous individual variation in the rate of physical changes in adulthood and also in the perceived impact and effect of such changes. Some persons reach their 80s or 90s with seemingly little change in their daily living routines, while others become increasingly incapacitated physically beginning as soon as their late 30s or early 40s. Individual perceptions, attitudes, and lifestyle choices are key determinants of differing responses to the aging process.

...the major milestones of adulthood are described in terms of psychological considerations....

Individual perceptions, attitudes, and lifestyle choices are key determinants of differing responses to the aging process.

Cultural influences, as well as biological and psychological factors, affect adult development. The concept of life stages provides a useful framework for understanding how people change as they grow older. A basic tenet of stage theories is that people progress through a predictable series of phases or stages in the course of their lives. Several theorists have attempted to explain developmental stages throughout the lifespan, while others have focused their efforts on understanding specific segments of the adult years. The basic concepts of several developmental theorists are summarized below. Since midlife blends into old age at varying rates for different individuals, some discussion of midlife development is included here as well. One caveat in this discussion, of course, is that life stage theories address normative aspects of development, or what it is that people share in common. The assessment of factors affecting individual development are necessary when individual older persons are the focus of attention.

...life stages theories address normative aspects of development, or what it is that people share in common.

Developmental Theories

Numerous theories have been proposed to explain development across the lifespan. The basic concepts of several illustrative theories are presented below.

Carl Jung

Jung (1971) described four stages of life, including childhood, young adulthood, middle age, and old age. He wrote little about old age, seeing it as similar to childhood wherein the individual is submerged in the unconscious in a state of regression. Jung was much more concerned with midlife, which he viewed as beginning in the mid-30s and extending until extreme old age. Jung's view of middle age was not entirely positive. He considered the first half of life to be spent in preparation for living and the second half in preparation for old age and dying. Many problems and frustrations arise during the second half of life. It is necessary to reexamine and change goals and values in order to adapt successfully to the later years.

It is necessary to reexamine and change goals and values in order to adapt successfully to the later years.

Though he did not write in the context of empowerment, one may conclude that Jung considered persons in the first half of life to have much more power than persons in the second half of life. He apparently did not view a need for empowerment in late life, which to him was not a particularly valued part of the life course.

Charlotte Buhler

Buhler (1967) proposed five phases of the life cycle which are centered around a process of setting life goals. These phases include ages 0–15, the age before goals are set; ages 15–25, when preliminary life experimentation occurs; ages 25–45, when life is perceived as finite and self-determination important to fulfillment; ages 45–65, a self-assessment phase when successes and failures are evaluated; and ages 65+, when goals remain fairly stable, though some goals may change and new ones may emerge. Changing needs related to retirement and health status, for example, may lead to older persons setting new goals. The ability to set and achieve goals is closely related to self-efficacy and empowerment.

Changing needs related to retirement and health status, for example, may lead to older persons setting new goals.

Daniel Levinson

Levinson (1980) proposed five stages of the life cycle, however his main focus was on the mid-life transition. He considered middle adulthood to include the ages of 40–65, late adulthood 60–85, and late, late adulthood ages 85+. Levinson studied 160 adult males and found that 80% encountered difficulties with their selves and the external world during the midlife transition, which typically occurred between the ages of 40 and 45. He viewed this transition as an opportunity for change and growth based on self-evaluation and the development of new values and life plans. As is true of other developmental theorists, Levinson viewed the unsuccessful resolution of the midlife transition as having an adverse effect on development during the remainder of the lifespan. Negative self-evaluations during midlife

...80% [of 160 male adults] encountered difficulties with their selves and the external world during the midlife transition....

can have a pervasive effect on feelings of self-efficacy during later life, particularly if persons in mid-life fail to set goals for their future.

Roger Gould

Gould (1980) proposed seven stages of adulthood based on a study of 524 men and women. These included the ages of 16–18, 18–22, 22–28, 29–34, 35–43, 43–53, and 53–60. Questioning of self and role confusion begins in the 29–34 period, while 35–43 is seen as a time when a sense of urgency is felt to achieve life goals. The awareness that life is finite contributes to a reassessment and revision of one's goals, followed by a settling down and acceptance of one's life between the ages of 43 and 53. The last stage, ages 53–60, is accompanied by an acceptance of the past, increased sense of tolerance, and a general mellowing of behavior and affect. Gould did not extend his theory to life in old age, though his last stage would imply that the later years are a time of little change or challenge.

The awareness that life is finite contributes to a reassessment and revision of one's goals....

Robert Havighurst

Havighurst (1972) proposed a lifespan theory based on learning principles. He suggested that each period of life includes certain skills, abilities, or tasks that persons must master in order to progress successfully to later developmental stages. Seven stages of life are described in this theory, each of which includes six to eight major developmental tasks. The period of middle adulthood, from 30 to 55, is the time of greatest productivity and social influence.

The period of middle adulthood...is the time of greatest productivity and social influence.

Among the major tasks of midlife, which must be mastered if later life stages are to be successfully encountered, are the following: (1) achieving adult social and civic responsibility, (2) establishing and maintaining economic standards of living, (3) assisting teen-age children to become responsible adults,

(4) developing adult leisure-time activities, (5) relating to one's spouse as a person, and (6) accepting the physiological changes of middle age.

The developmental tasks of later adulthood involve more of a defensive strategy than earlier periods.

The developmental tasks of later adulthood involve more of a defensive strategy than earlier periods. The goal is to hold on to various aspects of life, rather than to seize new opportunities. Havighurst described the major developmental tasks of old age as: adjusting to decreased physical strength and health, adjusting to retirement and reduced income, adjusting to the death of a spouse, establishing an explicit affiliation with one's age group, meeting social and civic obligations, and establishing satisfactory physical living arrangements. These tasks require adjusting to changes over which one may have little or no control

Eric Erikson

Erikson (1963) proposed a theory of lifespan development based on critical psychosocial crises which must be resolved. Each of eight periods of life is characterized by one central, universal, culturally determined polarized theme. The successful resolution of each crisis is necessary to the success of all future life stages. Thus, difficulties experienced at one stage may be the result of that stage only, or a combination of difficulties due to the unsuccessful resolution of prior stages. The eight stages posited by Erikson and the crisis associated with each are:

early infancy	birth–1 year	trust vs. mistrust
later infancy	1–2 years	autonomy vs. shame, doubt
early childhood	3–5 years	initiative vs. guilt
middle childhood	6–11 years	industry vs. inferiority
adolescence	12–20 years	identity vs. identity diffusion
early adulthood	20–35 years	intimacy vs. isolation
middle adulthood	35–65 years	generativity vs. stagnation
late adulthood	65+	integrity vs. despair

The issue of identity extends across the lifespan....

The issue of identity extends across the lifespan and tends to resurface during periods of stress and transitions between the various life stages. This is particularly true during the midlife period when the universal process of self-evaluation stimulates an examination of existing and desired goals, and also at the time of retirement. Generativity, the primary goal of midlife, refers to a desire to leave something of value to the next generation. It is similar to the task defined by Havighurst (1972) of assisting teenage children to become responsible and happy adults.

The central concern of later life is that of achieving integrity rather than despair. Older persons engage in a universal process of life review, the outcome of which can be either positive or negative. Those older persons who look back on their lives with a sense of satisfaction, a feeling that the life they have lived is the best they could have lived, achieve a sense of integrity which prepares them for death. Older persons who look back with regrets, wishing they could change decisions and courses of action which it is now too late to change, may experience a profound and overwhelming sense of despair. They may perceive that it is too late to have a happy life, or that their entire life has been wasted.

The central concern of later life is that of achieving integrity rather than despair.

Older persons who look back with regrets... may experience a profound and overwhelming sense of despair.

Riker and Myers (1990), in reviewing research relative to Erikson's theory, noted that the process of seeking integrity is most likely to occur in the sixth decade of life. Since persons now live an average of 15–20 years beyond that decade, it is possible to speculate on additional developmental stages and tasks which could occur very late in life. These could include a continuing search for spiritual wholeness and an integration of personal integrity with a world view which incorporates the higher order values of a global economy.

Other Theories of Adult Development

A variety of other theories of adult development have been proposed. They share in common a view of the unfolding of developmental potential according to an unvarying series of universal life stages. Optimum human development occurs when persons are able to successfully master the major developmental issues and tasks presented by each successive stage. Growth occurs as persons meet each successive developmental challenge.

Growth occurs as persons meet each successive developmental challenge.

In contrast to the stage-and-task-oriented developmental theories, are the theories which explain adulthood in terms of transitions and responses. These theories are discussed below.

Transition Theories

A number of theorists have proposed to explain adult behaviors on the basis of transitions. These theorists believe that life events, rather than chronological age, are important in understanding adult behavior. Transition theorists do not agree with the concept of life stages and tasks and think that research support is lacking in this area. They believe adults do not progress through a predetermined sequence of irreversible stages. On the other hand, the transition perspective views change as inevitable; thus coping with change is required for all adults.

Many transition theorists acknowledge the important role of critical life events as markers and milestones....

Many transition theorists acknowledge the important role of critical life events as markers and milestones which play a pivotal role in individual development (e.g., Lowenthal, Thurnher & Chiriboga, 1975). Rather than childhood events, it is these transition points which determine the course of a person's life. Vaillant (1977) noted that "it is not the isolated traumas of childhood that shape our future, but the quality of sustained relationships with other people" (p. 29). Neugarten (1976) further emphasized a process called "individual fanning out," in which the decisions made in an individual's life contribute to an increasing diversity among adults.

Schlossberg's Theory of Transitions

Schlossberg (1984) developed a comprehensive approach to counseling adults in transition, based on three major assumptions. First, she noted that adults in transition typically are confused and in need of assistance. Though they can identify the issues in their lives, such as divorce or job change, they need assistance in developing a plan to cope successfully with these issues. Second, she assumed that family and friends, as well as paraprofessional and professional helpers could assist persons in transition by listening, providing empathic understanding, and helping in the development of plans for coping with the changes in their lives. Third, she assumed that communication and counseling skills were necessary to provide the help needed.

...adults in transition typically are confused and in need of assistance.

Schlossberg (1984) defined a transition as "any event or non-event that results in change in relationships, routines, assumptions, and/or roles within the settings of self, work, family, health, and/or economics" (p. 43). Examples of transitions may be obvious life changes such as graduation from college, marriage, job entry, or birth of children. Transitions also may be events which were anticipated but did not occur, such as promotions, pregnancies, or marriage. What is essential is not so much the nature of the event or non-event, but the adult's perception of the change or transition. The same experience, such as menopause, may effect perceptions of self and relationships for some women but have no effect on others. For the latter women, Schlossberg (1984) believes that this event was not a transition because no change occurred.

There are essentially four types of transitions. **Anticipated transitions** are those which predictably occur in the course of one's lifespan and for which one thus may prepare. These include, for a majority of persons, marriage, birth of a first child, and retirement.

Anticipated transitions are those which predictably occur in the course of one's lifespan....

Unanticipated transitions are non-scheduled or unpredictable events....

Unanticipated transitions are non-scheduled or unpredictable events. These events include death of children, divorce, or sudden job loss, and they generally precipitate a crisis.

Chronic hassle transitions. These are continuous and pervasive experiences, such as marital incompatibility or conflict with co-workers, which are relatively permanent in nature. They tend to have a negative affect on self-concept and lead to an inability to resolve the conflicts or initiate change.

Nonevent transitions. Chronic hassles may explain why many older couples remain together in the absence of intimacy and communication—they simply become immobilized in dealing with their marital situation. These transitions are those an individual anticipates but which did not occur. Examples might include marriages, birth of children, college graduation, or terminal illness as a result of early medical diagnoses. In some instances, nonevent transitions are perceived as among the most stressful (George & Siegler, 1981). This is particularly true when persons planned for, anticipated, and wanted the event to happen. The transition to grandparenthood is an event over which older persons have little, if any, control. Though they may want grandchildren, the choice obviously lies with their children. A sense of loss may be experienced, particularly when older friends enthusiastically share stories and pictures of their own grandchildren.

...all transitions have an impact on an individual's life, and all require some methods of coping and adaptation.

Regardless of type, all transitions have an impact on an individual's life, and all require some methods of coping and adaptation. The outcome of any particular transition may be for better or for worse. An opportunity always exists for psychological growth as well as for psychological decline (Moos & Tsu, 1976). The context of the transition is an important determinant of the outcome. This context includes the relationship of the person to the transition, whether it is personal, interpersonal, or community in nature, and the setting in which the transition occurs. The setting can be self, family, friends, work, health, or economics. For older persons, the setting often involves several of these areas simultaneously.

Late Life Transitions. As people grow older, they may be expected to have the same types of needs and experience similar life events as persons of younger ages. What seems to differ is that needs may actually be greater, particularly since resources to meet these needs are increasingly less available with advancing age. These resources include personal relationships, finances, and social roles. Transitions for older persons may be negative as well as positive. Some of the major transitions involve losses, retirement, and grandparenthood.

Losses. Old age has been defined as a time of loss, since many (but not all) of the transitions of later life involve significant losses. Some of the major losses include loss of a spouse through death or divorce, loss of friends and family members through death or geographic separation, loss of job as a result of retirement, reduced income as a result of job loss, declining health, and loss of social status as a result of being older. Each loss requires an adaptation and a process of grieving for the loss. What is especially unique to the older population is the onset of multiple losses before the grieving process for any one is complete. What ensues is a phenomenon termed "bereavement overload." Similar in nature to stimulus overload, the need to grieve multiple losses simultaneously can immobilize and debilitate an older individual.

...many...of the transitions of later life involve significant losses.

...unique to the older population is the onset of multiple losses before the grieving process for any one is complete.

The resolution of losses takes time. Older persons must be allowed to grieve each loss, to explore the significance of the loss, and to seek other means of filling the void that is left in their lives. Often they need assistance in making the transition toward an acceptance of the loss and return to a healthy level of functioning. They also may need assistance in recognizing that it is normal to grieve for a loss, and may need help in expressing their grief.

Retirement. Retirement may be viewed as a psychosocial transition similar to job loss at any point in life. Although it may be expected or even anticipated, reactions to retirement are not always positive. Work fulfills many functions. Jobs provide access to social networks, a source of status, a productive way to use one's time, and also a source of income. The loss of these benefits at retirement is no less significant than such losses which may occur suddenly for a younger person who is fired or laid off.

On the other hand, the retirement transition can be quite positive, allowing more free time to choose one's activities and lifestyle. Many persons enjoy the opportunity to create a lifestyle of leisure. Others appreciate the freedom to choose whatever activities they will pursue, particularly hobbies or educational pursuits which had been postponed during their working years.

...the retirement transition can be quite positive, allowing more free time....

Grandparenthood. The transition to grandparenthood is another example of an event which is positive for some older persons and negative for others. Grandparenting offers many older adults a source of pleasure and esteem within their family and community. Grandparenting provides new family ties and can strengthen existing ones. Some grandparents have little time or energy for the grandparenting role, while for others it is a primary source of pleasure.

Grandparenting offers many older adults a source of pleasure and esteem within their family and community.

In short, the transitions of later adulthood are varied and offer the potential for both positive and negative adjustment reactions. These transitions provide a context for understanding older persons which is different from that provided by developmental approaches. Both types of theories share the notion that coping skills are required to deal with the circumstances of later life. When developmental challenges or transitions are not successfully negotiated, functioning may be impaired. Any one or more of the six life arenas discussed below could be involved.

Wellness: A Framework for Understanding Development and Transitions

Although individuals function as an integrated whole, a framework for understanding the various components of functioning can be helpful in assessing needs and providing assistance. A number of such frameworks have been proposed. Since empowerment has been defined as an attempt to help persons achieve their optimal level of functioning, a framework which is oriented in this fashion will be most useful here. The **wellness** literature provides useful strategies in this context.

Wellness has been defined as a "conscious and deliberate approach to an advanced state of physical and psychological/spiritual health" (Ardell, 1984, p. 5). Leafgren and Elsenrath (1986) defined the goal of wellness as being to "maximize the individual's well-being and to establish lifestyle patterns that promote individuals' well-being throughout their lives" (p. 5). This goal is entirely consistent with the definition and goal of empowerment provided in the Introduction.

Hettler (1980) defines the concept of wellness with a six-dimensional model. The key to optimum wellness revolves around lifestyle choices in each of these six dimensions. The six components of wellness are defined below in a developmental context. The developmental emphasis is stressed as wellness refers to an ongoing, lifetime process of personal choice and implementation. As was seen in earlier discussions, self-efficacy has a major effect on lifestyle choices in each of these six dimensions of wellness:

...wellness refers to an ongoing, lifetime process of personal choice and implementation.

Emotional Development. Emotional development incorporates one's feelings, attitudes, and values, as well as self-concept. Within the context of empowerment, self-efficacy and locus of control are important aspects of emotional well-being. Factors which might be included in this area are sexuality and intimacy, assertiveness training, stress, and depression (Hetherington & Loganbill, 1985).

Intellectual Development. Intellectual development includes expanding and using knowledge, particularly for creative and stimulating activities. Studying to learn new knowledge or skills, using acquired skills in the pursuit of one's hobbies, or teaching skills to others would be included here.

Physical Development. This aspect of development includes physical health and nutrition as well as regular physical exercise. Avoidance of negative lifestyle habits, such as excessive eating, smoking, or use of drugs is included here. Obtaining regular health screenings and engaging in positive addictions are important as well. In contrast to negative addictions, positive addictions refer to behaviors which enhance wellness and have become habits. Some examples are jogging, playing tennis, and meditation.

...positive addictions refer to behaviors which enhance wellness and have become habits.

Social Development. The ability to interact successfully with people and the environment and to form successful interpersonal relationships is what is meant by social health (Greenberg, 1985). Included is the pursuit of healthy, harmonious family relationships, as well as a sense of connectedness with society and nature.

Occupational Development. Preparation for employment as well as the satisfaction one obtains through gainful work efforts are part of occupational wellness. Attitudes about work are important, as are strategies for obtaining and maintaining work, preparation for careers, and the role of leisure in career planning.

Spiritual Development. Spirituality refers to a belief in some unifying force for existence. Spiritual development involves a search for meaning and purpose in human life and existence. An appreciation for nature and natural forces is part of spiritual wellness.

Spiritual development involves a search for meaning and purpose in human life and existence.

Each of these six aspects of development offers unique potentials for growth. Each aspect also may offer challenges to development in the later years. To the extent that they overlap, intersect, and interact, changes in one aspect of development or functioning affect changes in others. When people are younger, the areas of overlap may be quite limited. As persons age, however, the areas of overlap increase, so that changes in any one aspect of functioning are apt to have a greater impact on changes in other areas.

Physicians who work with older persons, particularly those who are "old-old" (over age 75) and/or physically frail, find this phenomenon of functional interaction to be one of the greatest difficulties in medical treatment and rehabilitation. A younger person who experiences an acute illness or a family quarrel is soon up and about with little disruption in other areas of their life. An older person experiencing an acute illness or family disruption may progress through a very different series of events.

For example, an older woman living alone who has an argument with an adult child may become quite upset. With no one to talk to, she may ruminate over the problem and become quite agitated. Perhaps she will forget to eat, or forget to drink adequate fluids, or forget to take medicines at the proper time. Alternately, she may forget she has taken medications already and accidentally overdose. Any of these actions (or lack of actions) can result in a medical emergency. The most common symptom of need for care would be mental and emotional confusion. Taken to an untrained physician, a misdiagnosis of a chronic condition, such as an organic brain syndrome, could result. If left untreated, a simple case of malnutrition, dehydration, or medication misuse could result in an irreversible and untreatable brain dysfunction. Removed from her normal environment, intellectual, emotional, physical, social, occupational (including leisure), and spiritual development and functioning could all be affected.

The most common symptom of need for care would be mental and emotional confusion.

The situation described here is not unique. It is much more likely to occur with older persons, and in fact has occurred with many in the past. It will be less likely to occur in the future if more physicians are trained and sensitized to the needs of older patients. It also will be less likely to occur if older persons and their families are empowered to recognize and respond to circumstances and needs before they become untreatable. In the next chapter, the needs of older persons are viewed in the context of a process through which personal power decreases. This process also provides a context for viewing potential avenues to empowerment of older individuals.

...the needs of older persons are viewed in the context of a process through which personal power decreases.

Chapter 4

Reactions to Late Life Stresses: Various Breakdown Patterns

As persons grow older, the variety of life circumstances and changes they experience require increasing needs for coping and adaptation. As mentioned earlier, many, or even most older persons cope with changes in their lives with little disruption of functioning. Other older persons find that formerly successful methods of coping are no longer effective. Even coping with seemingly positive changes, such as a move to more affordable housing requiring less upkeep, can be stressful and require an extended period of adjustment. Somehow the circumstances of aging may combine to create difficulties in adjustment even for the most competent individuals.

...most older persons cope with changes in their lives with little disruption of functioning.

In this chapter, maladaptive reactions to late life stresses are examined, first from the perspective of mental health needs of older persons as a whole. Then, the tenets of Social Breakdown Theory are reviewed as a basis for understanding dysfunctional behaviors of older people. The psychological implications of devalued status provide further support for the breakdown model. In the next two chapters, strategies for reversing the breakdown syndrome will be presented.

Mental Health and Aging

It has been fairly well documented that mental health concerns increase with advancing age. While exact numbers of older persons experiencing treatable mental health problems are difficult to determine, estimates vary from a low of 25% to a high of 65% of the older population being in need of care at any one time (Butler & Lewis, 1983; President's Commission on Mental Health, 1978). These figures include only needs for remedial interventions. When preventive care is included, the numbers may be much higher.

The many stresses, crises, and losses experienced by older people form the basis for their emotional reactions and subsequent mental health needs. When considered or treated early, most of these conditions and reactions are reversible. Unfortunately, older persons' access to needed counseling and mental health care is limited. On the one hand, today's older persons were raised at a time when independence was highly valued and mental health care was equated with psychiatric care for major mental disorders. Even when counseling is readily available, unless it is called something else, such as a life review or personal growth program, older persons tend not to participate voluntarily.

...today's older persons were raised at a time when independence was highly valued and mental health care was equated with psychiatric care....

On the other side, mental health services specifically for older persons have not kept pace with existing needs. Although older people comprise over 12% of the general population, and an even greater proportion of persons needing mental health care, only 2–4% of persons seen in public mental health clinics are themselves older. In spite of federal legislation mandating services, most mental health clinics do not have staff trained to work with older people and their families.

...most mental health clinics do not have staff trained to work with older people....

When care is provided for older clients, the setting typically is an inpatient one rather than outpatient. More than 60% of public mental hospital beds are occupied by persons over the age of 60. Over half of those persons were hospitalized as their first contact with mental health care. Presumably, at least some such hospitalizations could have been avoided if adequate efforts had been made to provide early intervention and treatment. Moreover, accurate diagnosis of existing problems of older persons is complicated by age-related changes and the unwillingness of family members to report problems due to shame or embarrassment. This is particularly apparent in cases of suicide, as many families both fail to seek needed care for older persons and report their suicides as some type of accidental or natural death. Suicides among older persons, already the highest of any age group, may actually be much higher than reported. This is further indication of the need for mental health care for older persons.

Clearly mental health and illness do not occur in isolation....

Clearly mental health and illness do not occur in isolation, but rather within some type of personal-social environment. Basic concepts of social labeling theory and self-theory suggest that environmental inputs can have both positive and negative consequences. To the extent that negative inputs are internalized, negative self-expectations can result in poor adjustment and eventually death. The process by which this occurs is discussed below.

The Social Breakdown Syndrome

Kuypers and Bengtson (1973) proposed the Social Breakdown Syndrome as an explanation of negative adjustment in old age. This theory incorporates a systems approach which includes individual, familial, and societal contexts. The theory also forms the basis for a social reconstruction model to reverse the breakdown, resulting in successful adaptation. Beyond this, the reconstruction model is reviewed in Chapter 5.

The Social Breakdown Syndrome was first presented by Zusman (1966) to explain the process of interaction between social inputs and self-concept which results in a self-perpetuating cycle of negative psychological functioning. Among the seven stages of breakdown proposed in this model, Kuypers and Bengtson (1973) considered four to be the most important.

...social breakdown is an existing precondition of susceptibility to psychological breakdown.

1. The **first stage** in social breakdown is an existing precondition of susceptibility to psychological breakdown. This precondition could exist due to identity problems or difficulty in applying appropriate standards to social relationships. For many older persons, the loss of status which accompanies retirement can create internal doubts as to one's capabilities, particularly if retirement was forced rather than chosen. For other older individuals, declining health may cause doubts of one's ability to continue living independently and arouses fears of becoming dependent.

2. The **second stage** in the breakdown model involves labeling of the older person as incompetent or deficient in some aspect of behavior. This labeling could originate with family, friends, or caregivers, or it could begin with negative societal perceptions of persons who are old. As noted earlier such perceptions are common, and are communicated to older persons in overt (e.g., forced retirement) and covert (e.g., simply being ignored) ways.

3. The **third stage** involves induction into a sickness role. This is a dependent position which, for younger persons, can have many secondary gains. Such gains include freedom from work and other responsibilities, caregiving from others, and time-out from dysfunctional relationships until the sick person is once again "well." The difference for younger persons is that the sick role usually is a temporary one. Once inducted into the sick role, an older person must learn and maintain that role. At the same time, previous skills required for independent functioning will atrophy due to disuse.

...previous skills required for independent functioning will atrophy due to disuse.

4. In the **fourth stage**, the older person identifies even more strongly with the sickness role, accompanied by a perception of him or herself as inadequate and incapable of independent action. Self-efficacy is quite impaired at this stage, with low expectations of successful outcomes of the individual's behavior.

By the fourth stage, the cycle may begin again with the first phase, but with an important difference. The older person is now even more susceptible to the breakdown sequence of events. The cycle continues in a negative, downward spiral, eventually ending in incapacity and death.

Bengtson (1973) argued that older persons are particularly susceptible to social labeling and the effects of ageism because of social and personal changes which occur in later life. Role loss, inappropriate normative information, and lack of appropriate reference groups:

> ...all serve to deprive the individual of feedback concerning who he is, what roles and behaviors he can perform, and what value he is to his social world...this feedback vacuum creates a vulnerability to, and dependence on, external sources of self-labeling, many of which communicate a stereotypic portrayal of the elderly as useless and obsolete....thus, the Social Breakdown Syndrome characterizes the dynamic relationship between susceptibility, negative labeling, and the development of psychological weakness. (Bengtson, 1973, pp. 47-48).

...older persons are particularly susceptible to social labeling and the effects of ageism....

Psychological Components of Social Breakdown

The vulnerability of older persons which results in the Social Breakdown Syndrome may be manifested in a variety of ways. Among the common psychological reactions which comprise the syndrome described here are **learned helplessness, change in locus of control from internal to external, depression,** and **discouragement.** Each of these reactions may lead to a decreased sense of self-esteem and self-efficacy, and decreased activity and involvement, thus perpetuating the negative cycle. A brief description of each of these reactions may help clarify implications for intervention.

Learned Helplessness

The phenomenon of learned helplessness was first identified by Seligman and Maier (1967) while studying animal behavior. They placed dogs in cages having electrified floors. When a shock was administered to the dogs in one group, they were able to jump over a small barrier to a side of the box which was not electrified. The other group of dogs was placed in cages where escape from the shock was not possible. The reactions of the two groups of animals to later shocks were radically different. Dogs in the escape-trained group continued to struggle over the barrier to escape the shock. Even when escape became possible, the dogs in the second group made no attempt to escape. Rather, they cowered and whimpered, having learned that escape was impossible. Even when these dogs later accidentally crossed the barrier and thus escaped the shock, they failed to learn that their movement caused the escape. They did not recognize that they had any control over the outcomes and continued to fail to escape the shock even when escape was possible.

People have reactions similar to those of laboratory animals when repeatedly placed in situations over which they have no control.

...an older woman who is placed in a nursing home against her will may thus learn that she is unable to control the decisions that affect her life.

People have reactions similar to those of laboratory animals when repeatedly placed in situations over which they have no control. When individuals believe (rightly or wrongly) that it is impossible to effect outcomes, they will stop trying. Further, opportunities for control will not be recognized when they occur. Once helplessness behavior has been learned, such behavior is extremely resistant to change. Not only will the initial behavior be avoided, but related behaviors will be avoided as well. For example, an older woman who is placed in a nursing home against her will may thus learn that she is unable to control the decisions that affect her life. She is now in a situation where she can no longer determine when she will eat her meals, she can no longer function as a hostess to visitors in the same manner as she used to do, and she experiences other areas of life where choices formerly made independently are now made for her. So, as she learns that she cannot control her life, even minor choices are perceived as outside of her control. If given choices for a menu, she may indicate no preference. In other aspects of her life she may become apathetic and withdrawn, as the perception of lack of control generalizes to all behaviors and circumstances.

Another example would be that of an older man forced to retire in spite of his desire and attempts to remain working. Lacking control over this major life decision, he may learn that he no longer has control over the major events in his life. Further, this feeling of helplessness may generalize to other circumstances, resulting in a passive approach to dealing with choices. He may become depressed and withdrawn in social relationships, and family and friends may find him less active than before in setting goals and priorities. When confronted with choices, his response may be simply that he does not care, or that it does not matter what happens next.

The helplessness syndrome can include any or all of the following behaviors: apathy, listlessness, lack of motivation, depression, negative self-beliefs, and difficulty in seeing relationships between responses and outcomes. As a result, people who have learned to be helpless will not recognize the successes they have achieved but will take personal responsibility for all failures (Greer & Wethered, 1987).

...people who have learned to be helpless will not recognize the successes they have achieved....

Abramson, Seligman & Teasdale (1978) reformulated this theory based on attributions. They hypothesized that the development of learned helplessness is based on three attributions which in turn are reflected in three types of beliefs: (1) the expectations that people hold concerning their future performance, (2) their beliefs about the reasons for future performance, and (3) their beliefs about the reasons for their success and failure. People who accept greater responsibility for their failures are more likely to feel helpless.

People who accept greater responsibility for their failures are more likely to feel helpless.

The three attributions identified in the reformulated theory of helplessness are internal-external, consistent-inconsistent, and global-specific. When the cause of events is perceived as internal, persons are inclined to accept more responsibility for their mistakes and are more likely to have negative expectations of future performance. Consistent patterns are more likely to lead to perceptions of future failure than are inconsistent ones, which could be perceived as being due to lack of effort or luck. When the cause of events is seen as global, extending across circumstances, rather than unique, the potential for development of learned helplessness is increased. An older person who experiences a number of almost simultaneous losses, e.g., job, spouse, health, may perceive little control over events and may thus develop a sense of hopelessness or negative expectations of the future.

...people develop learned helplessness on either a personal or universal level.

It seems that people develop learned helplessness on either a personal or universal level (Strecher, DeVellis, Becker & Rosenstock, 1986). Personal helplessness results when a person believes that he or she is unable to control a situation and lacks the responses to do so, but believes that others in the same circumstance would be able to do so. Universal helplessness refers to a situation where a person is unable to make a response, and also believes that others are helpless in that situation as well.

Unfortunately, many of the circumstances and changes of later life are ones over which individuals have little or no control. In keeping with the Social Breakdown model, when events occur which they are unable to affect, older persons may learn that they are unable to control their environment to as great an extent as was previously true (**stage 1**). Their self-esteem is affected negatively (**stage 2**), and they may begin to look to others to resolve problems (**stage 3**). As others provide assistance, it reinforces their perception of themselves as less capable of independent action (**stage 4**), leading to even fewer attempts to control events in their environment (**stage 1, again**). Since learned helplessness is remarkably resistant to

...learned helplessness is remarkably resistant to treatment....

treatment, it is clear that early intervention is necessary to stop the downward spiral of events.

The learned helplessness model is useful in understanding the passive behavior of many older persons when confronted with decisions. In fact, indecisive behavior of older people is one of the major concerns (and frustrations) raised by caregivers and family members. It may be assumed that these persons once did make choices, and that somehow their choices began to make less of a difference in their lives. In some instances, choices may even have led to undesired outcomes. Hence, a fear of making "the wrong choice" may be a part of the learned helplessness sequence for older individuals.

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Many family members have noticed that aging relatives do not tell their physicians the many complaints they are willing to share with the family. One possible explanation is that these older persons have "learned" that their physicians are very busy and do not have the time to listen to "an old person." Seeing themselves as helpless in dealing with medical care providers, older persons often fail to report their full range of symptoms and problems during medical visits. They continue to complain to family members, however, medical intervention is not provided.

Social-psychological theories of aging, particularly the disengagement theory, posit that behaviors such as withdrawal are "normal" for some older persons. Sometimes it is difficult to determine when passivity is the result of a "normal" developmental sequence or a learned behavior pattern which suggests low self-efficacy. Other factors need to be evaluated and considered.

Change in Locus of Control

Locus of control refers to basic beliefs about the decision-making factors or influences that affect people's lives. Such factors may be viewed as either internal or external. Internal control refers to a mindset that reinforcements are contingent on one's own behavior; thus, persons with an internal locus of control perceive a high degree of responsibility for their actions and the consequences of those actions. External control refers to a belief that reinforcements are not under one's own control, but under the control of someone else, luck, or fate (Silvern, 1986).

...persons with an internal locus of control perceive a high degree of responsibility for their actions....

Persons with an internal locus of control will accept personal responsibility for their actions or the consequences of those actions. For example, older persons who made a successful transition to a forced retirement might explain how happy they are with the activities they had chosen to fill their time. Such individuals perceive a high degree of involvement in the choice of their activities, based on having an internal locus of control. Older persons experiencing difficulty with a forced retirement might dwell on their unhappiness due to being denied the opportunity to continue working. Believing themselves unable to have any choice about such a major decision as whether to work or not, an older person with an external locus of control may fail to fill their time with other satisfying activities, believing that forces external to themselves would continue to inhibit their life satisfaction. The internal person might seek out activities while the external person might say, "why bother trying?"

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Beliefs about locus of control develop over the course of a lifetime and are reinforced by events and outcomes. Such belief systems provide a framework for decision making. Persons with an internal locus of control believe themselves capable of self-determination, goal setting, and personal choice. Those with an external locus of control believe that fate, or someone or something else, is responsible for the circumstances of their lives. Cognitively, affectively, and behaviorally oriented responses will reflect core beliefs about locus of control.

Slivinske and Fitch (1987) cited several studies of older persons in which locus of control was affected by experiences in which they perceived (or actually experienced) a loss of control over their environment. Concomitants of the loss of control included impaired physical and mental health, increased mortality rates, and declines in personal and social functioning. The authors concluded that, since many of these experiences were environmentally induced, it could be possible to prevent or attenuate the effects. On the positive side, it was found that older persons in nursing homes (typically a situation where little personal control is possible) became more active, optimistic, and hopeful when they experienced control-enhancing conditions. These conditions included educational interventions as well as teaching new coping skills to increase self-responsibility and facilitate an internal locus of control.

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Depression

Learned helplessness and experience with uncontrollable events typically results in depression (Seligman, 1975). Symptoms of depression include affective, cognitive, motivational, somatic, and behavioral symptoms. Though these symptoms are common to persons of all ages, evidence suggests that depressive symptoms and symptom clusters manifest differently in older persons than in younger ones. The differential diagnosis of depression in older persons is difficult, as many of the symptoms mimic those of organic brain disorders (Fry, 1986). Confusion and disorientation are common in late-life depression. Major depressions may be accompanied by hallucinations (Whanger & Myers, 1984).

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The primary affective symptom of depression is dysphoria. Feelings are dominated by sadness, inability to enjoy activities, pervasive fatigue, and loss of interest in ordinary activities such as eating, drinking, and sex.

Cognitive manifestations of depression include low self-esteem, and feelings of failure, helplessness, hopelessness, and powerlessness. Negative expectations of the future and low self-efficacy are common. In addition, depressed persons tend to criticize and blame themselves for any perceived failures of adaptation or action.

Motivational symptoms, or behavioral deficits, include minimal social participation, isolation, inability to perform ordinary work, slowed and monotone speech patterns, whispering, inability to laugh, and neglect of personal appearance. General slowness of physical responses also is common, including a slow gait and stooped posture.

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Somatic symptoms of depressive moods include headaches, disturbances of sleep patterns, gastrointestinal disorders, dizzy spells, rapid heart beat, and general fatigue and malaise. Other physical symptoms may occur, as hypochondriacal complaints have been found in up to two-thirds of all depressed individuals. Such complaints are especially common among older persons. While they may lack a vocabulary to identify feelings, and perceive psychological distress to be unacceptable, physical complaints and symptoms may be readily reported or even exaggerated. Expectations of aches, pains, and illness as a result of the aging process may serve to complicate diagnosis and treatment.

Behavioral excesses also occur among depressed individuals. These include consistent complaining about material problems, lack of affection from others, memory lapses, inability to concentrate, and so forth. Indecisiveness, feelings of guilt, and fears of being a burden to others may be repeatedly expressed. Paranoia often is a part of severe late-life depression (Fry, 1986).

Depression occurs frequently in old age as a reaction to loss.

Depression occurs frequently in old age as a reaction to loss. The inability to completely grieve each loss, resulting in bereavement overload, may contribute to a state of chronic depression in older individuals. They may become quite self-preoccupied and thus cause family and friends to stay away from them, further increasing their symptoms. This is a particularly difficult circumstance for adult children. The parent who for 30, 40, or 50 years has taken an interest in their activities may now express no interest at all. When the adult child tries to tell of his or her experiences or thoughts, the self-preoccupied aging parent may abruptly change the subject back to his or her own concerns. It is difficult for the adult child to experience this change without some degree of hurt feelings.

As their isolation increases, a tendency towards physical and emotional decline may be expected. Not only will the depressed older person tend to believe him or herself incapable of doing anything at all, family and friends may begin to believe the older person to be incompetent as well. The subtle communication of a lack of faith in the older person's abilities will contribute to their sense of discouragement in yet another interactive downward spiral of functioning.

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The description of discouragement provided here sounds much like the description of depression discussed earlier. The description of depression seemed much like someone with an external locus of control and a sense of learned helplessness. In fact, all of these descriptors relate to the same observed phenomena and have much in common. At the same time, each adds unique perspectives to our understanding of human behavior. Such diverse understandings are necessary when we attempt to intervene to provide assistance to older persons in need.

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Discouragement develops over time, often being the end result of numerous attempts at success which ended in failure. Discouragement may be specific to one situation or set of circumstances, or it may be total. When multiple failures are experienced, or multiple losses experienced, an individual's beliefs and expectations may be changed from an optimistic to a pessimistic outlook on life. Discouraged persons have a low sense of self-efficacy.

Decreased Self-Efficacy and Involvement

As seen in this discussion of the Social Breakdown Syndrome and accompanying psychological reactions, the breakdown cycle is self-perpetuating. As self-efficacy decreases, lack of self-esteem and negative self-expectations lead to further discouragement, withdrawal and lack of effort. Older persons understandably withdraw from social involvements when the end result of such involvements is continued labeling of themselves as less and less capable. As they internalize these perceptions, they do, in fact, actually become less and less capable.

...older persons...are in need of empowerment.

Empowerment was defined in Chapter 2 as nurturing a belief in one's own potency or sense of power and the positive impetus to action. Clearly, older persons in our society who have experienced the impact of the Social Breakdown Syndrome are in need of empowerment. Strategies for empowering them, from both remedial and developmental perspectives, are suggested in Chapters 5 and 6.

independently are now made for her. So, as she learns that she cannot control her life, even minor choices are perceived as outside of her control. If given choices for a menu, she may indicate no preference. In other aspects of her life she may become apathetic and withdrawn, as the perception of lack of control generalizes to all behaviors and circumstances.

Another example would be that of an older man forced to retire in spite of his desire and attempts to remain working. Lacking control over this major life decision, he may learn that he no longer has control over the major events in his life. Further, this feeling of helplessness may generalize to other circumstances, resulting in a passive approach to dealing with choices. He may become depressed and withdrawn in social relationships, and family and friends may find him less active than before in setting goals and priorities. When confronted with choices, his response may be simply that he does not care, or that it does not matter what happens next.

The helplessness syndrome can include any or all of the following behaviors: apathy, listlessness, lack of motivation, depression, negative self-beliefs, and difficulty in seeing relationships between responses and outcomes. As a result, people who have learned to be helpless will not recognize the successes they have achieved but will take personal responsibility for all failures (Greer & Wethered, 1987).

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Abramson, Seligman & Teasdale (1978) reformulated this theory based on attributions. They hypothesized that the development of learned helplessness is based on three attributions which in turn are reflected in three types of beliefs: (1) the expectations that people hold concerning their future performance, (2) their beliefs about the reasons for future performance, and (3) their beliefs about the reasons for their success and failure. People who accept greater responsibility for their failures are more likely to feel helpless.

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The three attributions identified in the reformulated theory of helplessness are internal-external, consistent-inconsistent, and global-specific. When the cause of events is perceived as internal, persons are inclined to accept more responsibility for their mistakes and are more likely to have negative expectations of future performance. Consistent patterns are more likely to lead to perceptions of future failure than are inconsistent ones, which could be perceived as being due to lack of effort or luck. When the cause of events is seen as global, extending across circumstances, rather than unique, the potential for development of learned helplessness is increased. An older person who experiences a number of almost simultaneous losses, e.g., job, spouse, health, may perceive little control over events and may thus develop a sense of hopelessness or negative expectations of the future.

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It seems that people develop learned helplessness on either a personal or universal level (Strecher, DeVellis, Becker & Rosenstock, 1986). Personal helplessness results when a person believes that he or she is unable to control a situation and lacks the responses to do so, but believes that others in the same circumstance would be able to do so. Universal helplessness refers to a situation where a person is unable to make a response, and also believes that others are helpless in that situation as well.

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Unfortunately, many of the circumstances and changes of later life are ones over which individuals have little or no control. In keeping with the Social Breakdown model, when events occur which they are unable to affect, older persons may learn that they are unable to control their environment to as great an extent as was previously true (**stage 1**). Their self-esteem is affected negatively (**stage 2**), and they may begin to look to others to resolve problems (**stage 3**). As others provide assistance, it reinforces their perception of themselves as less capable of independent action (**stage 4**), leading to even fewer attempts to control events in their environment (**stage 1, again**). Since learned helplessness is remarkably resistant to treatment, it is clear that early intervention is necessary to stop the downward spiral of events.

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As seen in this discussion of the Social Breakdown Syndrome and accompanying psychological reactions, the breakdown cycle is self-perpetuating. As self-efficacy decreases, lack of self-esteem and negative self-expectations lead to further discouragement, withdrawal and lack of effort. Older persons understandably withdraw from social involvements when the end result of such involvements is continued labeling of themselves as less and less capable. As they internalize these perceptions, they do, in fact, actually become less and less capable.

Empowerment was defined in Chapter 2 as nurturing a belief in one's own potency or sense of power and the positive impetus to action. Clearly, older persons in our society who have experienced the impact of the Social Breakdown Syndrome are in need of empowerment. Strategies for empowering them, from both remedial and developmental perspectives, are suggested in Chapters 5 and 6.

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Chapter 5

Empowerment Through Remediation: Reversing the Breakdown Syndrome

The first four chapters of this book provided a framework for viewing the needs of older persons for empowerment. The fourth chapter dealt specifically with the consequences of a lack of empowerment, namely, the Social Breakdown Syndrome and concomitant psychological reactions. In this chapter, techniques for stopping, slowing, and even reversing the Social Breakdown Syndrome are considered. These include societal, environmental, and individual interventions. Techniques for mobilizing individual, family, and community resources, based on the various models of helping reviewed in Chapter 2, are discussed. A review of stages in the empowerment process which may be necessary for helping disenfranchised groups of persons is presented.

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The Social Reconstruction Model

Kuypers and Bengtson (1973) proposed a model of social reconstruction to offset the negative effects of the Social Breakdown Syndrome. This model was referred to as the Social Reconstruction Syndrome, and subtitled "a benign cycle of increasing competence through social inputs" (p. 48). The underlying assumption of this model is that inputs may be made at any level in the Social Breakdown Syndrome to interrupt the cyclical chain of events. The outcome of such interruptions could be a temporary or permanent slowing, cessation, or reversal of the Syndrome.

...older persons in our society are vulnerable....

Social reconstruction is based on the assumption that older persons in our society are vulnerable and that a variety of approaches are required to best meet their multiple needs. These approaches could include societal, environmental, and psychological interventions at each stage of the breakdown process.

...persons who do not engage in productive activity are devalued.

Productive work activity is valued in American society to the point that persons who do not engage in productive activity are devalued. Although retirement is a normal phase of life in which persons are freed from the responsibilities of work, the lack of employment during this period still results in a devalued status as a result of the dominant social values. To the extent that self-worth is a reflection of the opinions of others, the self-esteem of older persons is lowered as a result of their not being gainfully employed. If self-worth were viewed as not contingent on economic productivity, older persons would be free to cultivate and enjoy alternate avenues to self-fulfillment. Involvement in volunteer efforts, grandparenting, and leisure pursuits, for example, could directly contribute to feelings of self-worth based on the intrinsic value of these efforts. Whether it is possible to accomplish the not-so-easy task of changing societal attitudes about what constitutes productive work is another matter.

Many older persons could remain living independently in their own homes if they had assistance....

A second intervention would promote adaptation and ability among older persons by improving the nature of and access to social services, e.g., providing better housing, transportation, and shopping assistance. Many older persons could remain living independently in their own homes if they had assistance with housekeeping, or preparation of meals, or a source of transportation for needed trips to hospitals, physicians offices, and shopping centers. The primary goal of such services should be to keep older persons independent, while a secondary goal would be to assist them in coping after significant declines in resources and self-esteem have occurred. The assumption underlying this second form of intervention is that coping skills of older persons will increase when the environment is modified to help them remain independent.

Third, the encouragement of self-efficacy through empowerment is a vital strategy for interrupting and reversing the breakdown cycle. By helping older persons experience a sense of control in the management of their lives, and by promoting a view of older persons as capable and self-determined, a sense of empowerment can be fostered. This will require significant modifications in the environment as well as in individual perceptions.

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If it is to work, the reconstruction model will require changes in society, in environments and settings where older persons live and function, and in the emotional response of older persons to their changing social and personal world. Strategies for effecting change in each of these three areas are discussed below.

Societal Aspects of Reconstruction

What is most clear concerning attitudes toward older persons is that these attitudes are generally negative. Providers of social and medical services to older persons, younger persons, employers, family members, children, and adolescents, have all been shown to have primarily negative attitudes toward aging and older persons. These attitudes are stable over time and extremely resistant to change. As was seen earlier, these negative attitudes affect older persons themselves through a process of internalization and identification.

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...our society needs to reexamine the primary tasks of education, work and retirement.

Bolles (1978) suggested that our society needs to reexamine the primary tasks of education, work and retirement. Currently these may be seen as three separate "boxes," the contents of which are not often to be mixed. During the first 20 or so years of our lives, we devote our efforts to education. For the next 40–50 years we are engaged in work activities, followed by the retirement years. Bolles suggested that we could live more satisfying and fulfilling lives if the contents of each box were distributed across the lifespan. An adult, for example, might work for several years, followed by a period of leisure, a time for education, then a return to work for several more years. The rationale for stockpiling leisure time until late in life results in lower status for leisure pursuits (and those who pursue them!) and, for many persons, less energy and/or resources which result in a restricted range of leisure choices. If Bolles' paradigm were followed, it is conceivable that education, work, and retirement would be viewed as having equal status as gainful pursuits.

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A variety of strategies for changing attitudes have been proposed, the most effective of which seem to be education and personal experience. These methods seem to work better when they are part of the attitude formation process, rather than occurring as later attempts to change attitudes once formed. Imagine a situation where children in their preschool years were taught that their lives would be lived according to Bolles' paradigm! They would view education, work, and retirement from an integrated perspective, each having value and needing effective planning across the totality of the lifespan. Aging would then have a greater potential to be viewed as *a part of* the lifespan rather than *apart from* the rest of life.

The graying of America is bringing increasing numbers of persons into their later years.

The graying of America is bringing increasing numbers of persons into their later years. Among these are the baby boomers, a group of persons who are reaching old age with somewhat different perspectives and values than those held by today's older persons. The baby boomers are more assertive, independent, and aware of their needs and rights. They are more likely to advocate for and even demand societal changes to accommodate their lifestyles and preferences.

Several years ago there were few middle-aged and older heros or heroines in the media. When they appeared in television commercials, older persons were depicted as sitting on porches in rocking chairs reaching for bottles of Geritol. Today older persons are depicted quite differently. "The Golden Girls" is a popular evening situation comedy on television with three middle aged-women and one aging parent in the starring roles. A contemporary automobile commercial depicts an elderly gentleman riding in his car grinning and shaking his head about his 70-year-old son—who then appears in his sporty car with several young, attractive, scantily clad women chasing after him with outstretched arms. The car, of course, is supposed to be the center of attention. The message is that an older man in a sporty car can be pretty sexy, indeed!

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As older persons become the dominant age group in society, some changes in perceptions of aging may be anticipated. Older persons are the major consumers of many goods, thus advertising campaigns will increasingly be directed toward older consumers. This trend will result in even more advertising directed at older consumers, placing aging in a more positive context. Persons who view this advertising will be influenced toward increasingly positive views of the aging population.

Of course, these positive trends do not in any way attenuate the need to actively advocate *now* for needed changes in the perception of older persons in our society. We still have a long way to go. Changes in legislation and public policy, such as the development of a national "older worker policy," additional raises in the retirement age, changes in social security benefits and elder abuse laws, and legislation which addresses the needs of caregivers, will serve as catalysts for societal changes to improve the quality of life for older people. Persons in the helping professions have a role to play as advocates for the human rights and needs of all citizens, including those who are growing older. The settings in which these professionals work, as well

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as the settings in which older persons are found, can have a profound impact on the empowerment process.

Other Components of Reconstruction

Ashcroft (1987) noted that empowering cannot work if it is something done only during certain hours or only on certain days. "It must be pervasive, with constant conscious, committed action to be fully successful.... Empowering needs to be a philosophy" (p. 151). Everything that happens to an older person must be screened through a filter of empowering concepts, issues, ideas, and strategies.

Organizations and settings can be arranged along a continuum, with one end promoting and encouraging empowerment and the other contributing to a lack of empowerment (Cummins, 1986). Persons empowered by their experiences within an educational setting, for example, develop self-confidence, motivation, and the ability to succeed academically. As a result, their long-term academic performance is successful. Persons who are disempowered or disabled as a result of educational experiences do not develop the necessary cognitive or emotional foundations to perform academically, thus their actual long-term academic performance turns out to be poor.

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A written philosophy of empowerment is, unfortunately, not enough. Within educational settings, for example, minority students presumably have equal access to accomplishment. Thus empowered, any failures must be due to their own inferiority. The psychological components of the empowerment process must not be ignored. Clearly, if the process is to be effective, those who are empowered must perceive themselves to be such.

In a similar example, older persons may live in an environment (e.g., a nursing home) which encourages their active participation in decisions affecting their daily lives. This could include purchase of cars or vans for the facility, planning of group meals, or scheduling of leisure activities, or even whether the blinds in their room should be opened. Older persons who are actively involved in planning and controlling their daily living circumstances will thus be empowered with the self-confidence, motivation, and ability to believe they *can* control their lives. Older persons who are disempowered or disabled as a result of an environment which deprives them of decision-making opportunities in their daily lives, may be expected to perform cognitively and emotionally in a manner which reinforces perceptions of them as incapable.

One way to empower persons…is to provide a means of involvement which promotes a sense of ownership and control.

One way to empower persons in various settings, then, is to provide a means of involvement which promotes a sense of ownership and control. Advisory boards and resident panels are examples of strategies for involving older persons in decision making on their own behalf. Unfortunately, not all older persons will be able to participate in these boards, leaving those who are already assertive and empowered to take the leading roles. Older persons can be encouraged to move comfortably into the challenge of leadership positions through education and by focusing on their past experience. Correspondingly, administrators and staff in settings serving older persons may need some "un-leadership" training, attitude-adjustment, or other educational efforts to assist them in achieving a commitment to a philosophy of empowerment. It may be difficult to change their fundamental beliefs about the capability or incapability of older individuals or the older population as a whole.

In some settings, especially long-term care and assisted housing environments, advisory panels which include family members are important. Such panels provide links between family members and residents, allowing for the development of programs and services that meet the needs of both. For example, transportation services provided through a housing complex for older persons may relieve relatives of the need to take time from employment to transport older persons

When family members are included in decision making, they are more likely to develop a sense of efficacy....

to medical appointments. Also, making counseling services available can help everyone communicate better and will encourage joint problem solving. When family members are included in decision making, they are more likely to develop a sense of efficacy which is most helpful in dealing with agencies as well as with their aging relatives (Cummins, 1986).

The full involvement of older persons and their families as part of the continuum of care may require both programmatic and educational interventions for optimal success. Programmatic emphases would be the specific goals and resources mobilized on behalf of older persons. Given a large array of needs, and usually some restriction of available resources, it is necessary to set priorities for services and also for who is to receive those services. Educational interventions can help older persons and their families better understand the aging process and the needs of older persons. Such knowledge will be important in the program planning process.

Educational interventions can help older persons...understand the aging process....

In Chapter 2, models of helping and their relationship to empowerment were considered. The enlightenment model, in which persons are seen as responsible for their own problems but not for the solutions to those problems, is one of the predominant models used in social service programs. This is a deficiency perspective, as is the medical model, in which the victim is blamed for being the instigator of the circumstances he or she is enduring (Cochran, 1987). This philosophy results in the requirement that individuals clearly demonstrate their incompetence before eligibility for needed social services may be provided. Entitlement programs thus become self-defeating, since potential recipients realize they must accept "an arbitrary public definition of themselves as incompetent" (Cochran, 1987, p. 21). The consumer is placed in the role of passive recipient, which further disempowers people who already find themselves in the unfortunate position of needing assistance.

The consumer is placed in the role of passive recipient, which further disempowers people....

An alternate approach would be one which allows universal entitlement to needed services. The Older Americans Act, first passed in 1965 and amended several times since, is based on this approach. Eligibility for services, all of which are community-based and designed to help older persons remain living independently in their own homes as long as possible, is established on the basis of being aged 60 or above, or having a spouse in that age group. As time has passed and the needs of the older population far surpassed available resources, programs operating under this act have had to establish some priorities for those who are eligible to receive services. Income is a major consideration; however, a very liberal sliding scale is used. This type of social service program is much more consistent with a philosophy of empowerment.

While it is possible to design and implement empowerment-based programs and services, an equally important consideration is the modification of existing programs and services to incorporate a philosophy of empowerment. The medical model and the enlightenment model are commonly encountered by older persons in need of assistance. As mentioned earlier, the use of empowerment approaches in such settings, as now constituted, could be counterproductive or even harmful to older individuals and their families. For the medical model to incorporate empowerment, a paradigm shift from an illness model to a wellness model may be required. As will be discussed in Chapter 6, the wellness model operates on an assumption of personal choice and responsibility for making lifestyle choices which promote healthy living. Such a model would increase the self-efficacy perceptions of older persons in coping with physical changes (the medical model decreases such perceptions). This change would move the medical model towards a modified moral model, or preferably towards a compensatory model, where people are seen as responsible for their own solutions.

For the medical model to incorporate empowerment, a paradigm shift from an illness model to a wellness model may be required.

The introduction of empowerment into the enlightenment model would move it also toward a compensatory framework. People would be seen as having an important role in finding and implementing the solutions to their problems. An increase in the prevalence of an empowering philosophy in models of helping would enhance the self-determination of older persons and increase their perceived sense of control over their lives.

When older persons and their families are involved in planning, evaluating, and setting priorities for the services they receive, the ultimate goal of fostering independence among individuals and families will be an integral part of each of the services provided. An empowering philosophy will mandate involvement of individuals and family members in shaping the circumstances of their lives to the fullest extent possible. As this philosophy is implemented, the varied psychological needs of individual older persons may require differing interventions and approaches to empowerment.

An empowering philosophy will mandate involvement of individuals and family members in shaping the circumstances of their lives....

Psychological Aspects of Reconstruction

Several psychological reactions inherent in the Social Breakdown Syndrome were discussed earlier. These include learned helplessness, change in locus of control from internal to external, depression, and discouragement. The negative impact of each reaction on self-esteem and self-efficacy was considered. Efforts to reverse the Breakdown Syndrome may require interventions tailored to each of these reactions. These interventions may be individual in nature or they may involve groups.

The support network of older persons is an important source of and for intervention and treatment. Family and friends can be part of the treatment team that facilitates social reconstruction. Alternately, these same persons may experience identical psychological

The support network of older persons is an important source...for intervention and treatment.

reactions to the circumstances of later life as those experienced by older individuals, and they may be immobilized and unable to respond to the same extent as their aging relatives. Lacking resources for responding, family members and friends may react in ways which are counterproductive, hurtful, or dysfunctional. The anger and resentment of adult children when forced to cope with role reversals caused by an aging parent's infirmities, for example, may interfere with effective empowerment efforts. The family may need to be the unit of treatment, or at least an integral part of treatment efforts, and external supports for family members may be required.

The anger and resentment of adult children... may interfere with effective empowerment efforts.

Overcoming Learned Helplessness and Perceived Lack of Control

Learned helplessness and changes in perception from an internal to an external locus of control are psychological reactions to circumstances in which personal control is ineffective. These phenomena are accompanied by a reduced sense of self-esteem and well-being. To overcome these reactions, some means of providing the experience of being in control will be required. This is easier said than done, and may be more difficult in some settings, such as long term care (e.g., nursing homes), than in others, such as independent living environments.

The relationship of the setting to learned helplessness reflects in part the nature of the setting itself as well as the type of older persons who form the peer reference group. Some settings by their very nature require a greater degree of structure and level of administrative control for efficient operation, while others function as a loose compilation of autonomous units or individuals. In some settings, peer reference groups are comprised of healthy, independent older persons actively engaged in numerous self-determined pursuits. Living in such a setting provides a continual

The relationship of the setting to learned helplessness reflects in part the nature of the setting itself....

source of stimulation and role models with a predominately internal locus of control. Other settings, such as those that provide skilled nursing care, may foster a false belief that decline and total dependence are inevitable. Such beliefs are reinforced by settings which reduce personal power through administrative rules.

Older persons who have learned to be helpless need assistance in sorting out the consequences, both good and bad, which can be attributed to their behavior, as opposed to the behavior of others, or to the general circumstances in which they find themselves (Zimmerman, 1988). It is necessary to sort out consequences in relation to time, noting that what happened in the past need not necessarily occur again in the future. Further, events which occur in one context need not necessarily generalize to other contexts. Environmental modifications may be required in order to structure experiences where older persons experience successful outcomes as a result of their own actions.

...older persons can take part in decisions about where they are going to live and what their daily living routine will be.

Even when long-term care is required, older persons can take part in decisions about where they are going to live and what their daily living routine will be. Though it will be a painful process, selection of clothing and personal items to take to the new home, identification of items to be given to particular family members and friends, and general disposition of personal property are decisions which must be made by an older person to help foster a sense of control even under the most dire of circumstances. To make such decisions for an older relative, even under the guise of "sparing their feelings," can result in a sense of loss which can never quite be resolved.

Cognitive and perceptual distortions of the significance of events can lead to learned helplessness even in the absence of objective facts. Greer and Wethered (1987) discuss these distortions and note that they are based on specific attributions which are indicative of learned helplessness. Examples of such attributions are:

"I must be dumb."	internal attribution
"My dog chewed it up."	external attribution
"I never do anything right."	consistent attribution
"Sometimes I can't remember names."	inconsistent attribution
"Nobody wants to be with me."	global attribution
"My son doesn't like my cooking."	specific attribution

Counselor interventions to deal with each of these types of attributions will vary. Inappropriate internal attributions are best dealt with by changing the focus from personal responsibility to external influences. An example would be to focus on the incongruity of believing oneself to be dumb when presented with a new situation for which one has not yet learned a successful response. External attributions should be validated when they are appropriate, and accurate attributions encouraged when they are not.

Consistent attributions require a focus on past control and successes....

Consistent attributions require a focus on past control and successes, with reinforcement for successful outcomes and reassurance that any failures were not part of a predictable, stable pattern. Inconsistent attributions may be handled by discussing successes and failures and reinforcing the notion that one is good at some things and not at others.

Global attributions may be minimized through a focus on successful experiences in which the older person took control of situations. Specific attributions may sometimes need to be affirmed, including those which point to successful experiences. Often an older person will admit to a success, but refuse to generalize to a perception of him or herself as a capable individual. It may be helpful to point out that older persons in general are survivors—look how long they have lived!

Counselors will need to assist older persons and their families in setting realistic, achievable goals....

Counselors will need to assist older persons and their families in setting realistic, achievable goals to help overcome feelings of learned helplessness and lack of control. Accurate appraisals of personal and familial strengths and resources will be necessary. Some balance must be made between structuring the environment to permit easy successes which may be discounted and providing enough challenge to foster a sense of accomplishment which will be internalized and generalized. Greer and Wethered (1987) suggest that the crux of helping persons overcome learned helplessness lies in assisting them in:

- setting realistic and attainable goals,
- seeking opportunities for success,
- understanding real causes for failure, and
- learning to use positive feedback.

Increases in self-esteem and feelings of self-efficacy may be expected when these suggestions are implemented successfully. In fact, older persons who experience these types of interventions are more hopeful, more active, and function at a higher level than similar control groups.

...many of the problems of older persons can be explained in terms of loss of control over their environment.

Research on control-enhancing interventions with older persons has yielded interesting and primarily positive results. Slivinske and Fitch (1987) observed that many of the problems of older persons can be explained in terms of loss of control over their environment. Such losses lead to impaired physical and mental health and increased mortality. They then designed a study in which older persons attended classes to help them in achieving control over their environment. The classes provided knowledge and skill development opportunities designed to improve the quality of life through stress management, nutritional awareness, physical fitness, self-responsibility and spirituality. Both perceived level of control and wellness were improved for the study participants, a group of independent older persons living in the community. Further, the authors concluded that at least some of the declines thought to be due to biological aging may be prevented or reversed through effective psychosocial interventions.

...some of the declines thought to be due to biological aging may be prevented or reversed through effective psychosocial interventions.

Coping with Depression and Discouragement

Depression has been identified as the most common mental health concern among older persons. It can be an overwhelming emotion which immobilizes an individual and leads to a self-perpetuating cycle of withdrawal, isolation, and declining physical and mental health. Numerous techniques have been suggested for treating depression. The most extreme is electroshock therapy, which is the treatment of choice for extremely frail older persons with depression that may be life threatening. Most older persons seem to benefit from a combination of cognitive and behavioral approaches. These are discussed in detail in a variety of sources (e.g., Fry, 1986) and will not be reviewed here.

The successful treatment of depression in older people involves obtaining baseline behavioral data, examining self-talk and cognitions, and developing a series of interventions to change both behavior and cognitions in an attempt to alleviate the depressive episode. An older woman depressed over the loss of her husband provides an example of how this treatment works. After more than two years, she is still not eating regularly, is unable to sleep, is obsessed with thoughts of suicide, and feels overwhelmed with guilt over her negative emotions and her inability to go on with her life.

The successful treatment of depression in older people involves obtaining baseline behavioral data....

The initial assessment process would involve her directly in determining the exact nature and extent of each of her behavioral problems, as well as assessing the negative self-statements she feels unable to control which contribute to her depressed mood. A plan is developed which requires her to maintain a log of pleasurable and unpleasant events each day. The log is brought to each therapy session. The schedule of pleasant events is used to develop a behavioral plan which substitutes pleasant events for unpleasant ones, and positive self-statements for negative ones. She may even be taught a variety of cognitive techniques to increase her awareness of her own negative thought processes and how those maintain her depressed mood. As increasing numbers of positive experiences are allowed into her awareness, and as she receives reinforcement about her ability to control the occurrence of such events, her depression will finally begin to lift.

The schedule of pleasant events is used to develop a behavioral plan which substitutes pleasant events for unpleasant ones....

In order for cognitive-behavioral treatments to work, the older person must be motivated to participate. "Encouragement" is a technique that:

- provides motivation
- builds the self-esteem required to participate in treatment
- offers useful suggestions for living even in the absence of a need for treatment

Encouragement was defined earlier as a process of helping others focus on their strengths and develop a sense of self-worth. Sweeney (1989) identified seven actions which are included in the encouragement process:

- **What** one is doing is more important than how one is doing.
- The **present** is the focus more so than with the past or future.
- The **deed** is what is important rather than the doer.
- The **effort** is to be emphasized rather than the outcome.
- **Intrinsic** motivation (i.e., a sense of personal satisfaction, enjoyment, challenge) is to be expressed rather than extrinsic (i.e., praise from others for a job well done).

- What is **being learned** is more important than what is not being learned.
- What is **being done correctly** is more important than what is not being done correctly. (pp. 109-110)

These seven actions are repeatedly stressed to the discouraged individual, providing the impetus to reevaluate one's basic attitudes and assumptions toward life. The encouragement process enables older persons to maximize a sense of personal control over the choices in their lives. Since a major focus is on attitudes, this process offers the potential for positive lifestyle choices even when objective circumstances are uncontrollable. Even in the most difficult of times, each person is free to choose the attitudes and emotional reactions they will maintain in conscious awareness.

The difference between older persons who are discouraged and those who are not may be seen in their attitudes and outlook on life. Older persons who experience each new day as an exciting opportunity for growth may be seen as living life to its fullest. They perceive themselves as active participants and indeed don't want to miss anything! New or challenging activities are approached with a sense of excitement and the knowledge that even if one does not succeed, the joy is in the doing rather than the outcome.

The difference between older persons who are discouraged and those who are not may be seen in their attitudes and outlook on life.

Discouraged older persons may be withdrawn and unwilling to take risks. New opportunities are viewed with a sense of foreboding and danger, as if they were designed as opportunities for failure, shame, or embarrassment. Rather than try, they will discount the importance of the activity. The mere act of **not** trying further reinforces their view of themselves as incapable, inactive, undesirable "old" persons. Friends and relatives frequently become frustrated and even angry at their many excuses for passivity. At the root of their discouragement is a low sense of self-efficacy.

Discouraged older persons may be withdrawn and unwilling to take risks.

As an empowerment process, encouragement provides a vehicle for enhancing self-efficacy. Through active communication and encouragement, discouraged older persons may be helped to choose goals that they feel capable of attaining, and to develop and implement strategies to achieve those goals. Encouragement of the effort and the learning process involved take the focus away from failure experiences and place an emphasis on the successful realization of personally determined and desired outcomes. Even minor achievements are of major consequence when treated with an encouraging philosophy. As older persons begin to experience a sense of self-efficacy through encouragement, they will begin to attempt a greater range of experiences. The higher the level of self-efficacy becomes, the greater will be both the capacity for behavior change and persistence in personal efforts until success is realized (Bandura, 1982). In essence, this is the goal of the empowerment process.

As an empowerment process, encouragement provides a vehicle for enhancing self-efficacy.

Stages of the Empowerment Process

Much of the literature on empowerment relates to persons of minority status, including ethnic minorities and persons with disabilities. Political empowerment is contrasted to disadvantagement. It is curious in a way that empowerment of older persons should become a part of this literature, since the older population is fast becoming a majority, and one with potentially great political influence.

...the older population is fast becoming a majority, and one with potentially great political influence.

Condeluchi (1989) viewed injustice and oppression as widespread in our society. Using disabled persons as an example, he explained how injustices become deep-rooted, conditioned and unconscious. Society may recognize the injustices faced by oppressed groups, but action will not occur until those who are oppressed raise the issue. In short, those who are oppressed "must be empowered to state their case, raise their case, raise the issues, push for change" (p. 12). He proposed three steps in the empowerment process, noting that these can occur concurrently as well as autonomously.

The first stage of empowerment... is that of raising consciousness....

The first stage of empowerment, according to Condeluchi, is that of raising consciousness, of increasing sensitivity and awareness of the general public to the situation of oppression. Along with promoting awareness, a desire for change must be fostered. The second stage of empowerment is to find a target which is responsible for the situation. That target can be a law, regulation, or group of people. In the third stage, a strategy is selected and matched to the particular target identified. The process for gaining power is viewed as difficult, leaving the disempowered group in a position of demanding rights and recognition.

Checkoway and Norsman (1986) viewed empowerment as a process wherein (disabled) persons must band together to support one another in a fight for independence and the right to live normal lives in the mainstream of society. Barriers to full participation are multiple and interactive, including physical and mental impairments, lack of accessible transportation and buildings, lack of access to education and employment, and lack of representation in agencies and decision-making groups. These are the same barriers experienced by subgroups of older persons at various times. The same strategies which have been found to benefit disabled persons thus may benefit those working with and on behalf of older persons.

The importance of education and training in the empowerment process cannot be overemphasized.

The importance of education and training in the empowerment process cannot be overemphasized. Education and training can strengthen involvement and help overcome the "participation gap" which exists among disabled and other non-empowered groups. Educational efforts bring persons together to develop coalitions and organize for action. Needed

Needed programs may be planned at the community level, leading to grass-roots involvement....

programs may be planned at the community level, leading to grass-roots involvement and community-level changes. As persons realize the impact they can have in their community, they will experience a sense of collective efficacy which will promote additional efforts at problem solving. The challenge of community participation is that the leaders often are not members of the group seeking empowerment. They can advocate for change, plan programs, and even effect changes, but the goal will not be fully met until the affected individuals feel a sense of empowerment.

Persons with a high sense of self-efficacy will persevere in the face of challenges.

Empowerment, then, requires patience, an ability to mobilize others, and a need to assure that those needing to experience a sense of self-efficacy are able to do so. Regardless of how the process begins, an ongoing means of fostering self-empowerment, or self-encouragement, needs to occur. It was mentioned earlier that self-efficacy is self-perpetuating: Persons with a high sense of self-efficacy will persevere in the face of challenges. The process for empowerment of individuals must build such a sense of self-efficacy.

...older persons once knew, and knew well, the relationship between planning, discipline, work, and accomplishment.

Davis (1988) presented a fairly simple 10-week plan for empowerment. The plan requires choosing goals for each week, monitoring the completion of each goal, and encouraging confidence through a focus on self-discipline and achievement. This empowerment exercise involved the educational goal of preparing for the GED examination. The study guide was broken down into ten segments, with one segment including exercises set as the goal for each week. By stating the goals, monitoring their progress each week, and completing the 10-week plan, Davis' students were able to learn the relationship between planning, discipline, work, and accomplishment.

The strategy used by Davis may work equally well for older persons; however, one caveat should be mentioned. It is entirely likely that older persons once knew, and knew well, the relationship between planning, discipline, work, and accomplishment. However, also likely is that the circumstances of later life, particularly losses, have led to a passive orientation, sense of victimization and discouragement and a low sense of self-efficacy. These circumstances supercede their previous ability to plan and work toward accomplishments in a disciplined way.

With time, trial and error, research, commitment, and patience, more and more strategies for empowerment of older persons may become evident. With time, too, such strategies may become less necessary. The goal of effecting societal change and changes in the philosophy of settings and agencies can lead to a pervasive philosophy of empowerment grounded in a concern for the human rights and dignity of all citizens, regardless of age.

Until that time, however, remedial needs must be addressed and preventive approaches designed and implemented which will enable older persons to face the challenges in their lives with efficacy and determination rather than breakdown and discouragement. Such preventive orientations are discussed in Chapter 6.

...remedial needs must be addressed and preventive approaches designed and implemented....

Chapter 6

Empowerment Through Developmental Approaches

Developmental approaches are often used as synonyms for prevention.

Developmental approaches are often used as synonyms for prevention. Thus, an understanding of prevention may provide a foundation for discussing these approaches. Developmental approaches offer much more than prevention, however, in that they incorporate remedial needs from the perspective of "lifespan" human needs. In this chapter, prevention is defined and discussed as it relates to developmental approaches. This discussion leads to the conclusion that a wellness philosophy may provide an optimum perspective for viewing empowerment.

...the potential for empowerment through wellness is explored.

The wellness model addresses needs in the area of prevention as well as remediation. This model is represented in the wellness movement, defined by Dunn (1959) as encouraging the acquisition of skills that promote "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable within the environment where he (sic) is functioning" (p. 447). In this chapter, the potential for empowerment through wellness is explored. After reviewing what is meant by prevention, an overview of the wellness philosophy is provided. Next, strategies for empowerment in each of the six dimensions of wellness are discussed. The third section deals with wellness aspects of agencies and settings, and the last provides a brief discussion of wellness as a lifespan concern.

Prevention and Empowerment

Prevention can be viewed along a continuum that extends from primary through secondary to tertiary interventions. Borrowing from the community mental health model, **primary** prevention refers to environmental interventions intended to lower the incidence of mental disorders by counteracting or removing stressful social conditions which precipitate or cause those disorders. **Secondary** prevention, intended to reduce the prevalence of mental disorders, is concerned with early identification and treatment to prevent the development of significant, advanced illnesses. **Tertiary** prevention is targeted toward reducing the rate of residual defective functioning, hence rehabilitative efforts are included in this model (Gregory & Smeltzer, 1983).

This three-level model of prevention incorporates the possibility of intervention at all levels, depending on the needs of the individual or group. Each of the three levels clearly includes an opportunity for using developmental methods. Primary [prevention] methods build healthy environments for optimum human development. Model retirement communities which include a range of needed services and a continuum of care are an example of primary prevention. Secondary methods incorporate medical and surgical care and short-term rehabilitative therapies, and are designed to facilitate a rapid return to "normal" functioning. Tertiary methods help persons overcome the limitations of various disabilities and return to the pursuit of optimum development within their functional limitations. These include long-term rehabilitative therapies and retraining in daily living and vocational skills.

Primary [prevention] methods build healthy environments for optimum human development.

While all three levels of prevention may be viewed as conceptually different from the remedial approaches discussed in earlier chapters, primary prevention is clearly the area of least overlap among the various models. If all efforts at primary prevention were successful, no remediation would ever be required.

Unfortunately, this ideal can be reached only in isolated instances, such as the use of inoculation to minimize or even eradicate the incidence of polio throughout the world.

Primary prevention addresses the goal of health, defined in two ways. The medical community defines health as the absence of illness or disease. From an empowerment perspective, health is a positive state of well-being achieved through proactive means.

...health is a positive state of well-being achieved through proactive means.

Enough is known about lifespan human development to suggest that minor physical and mental health concerns in the younger years often become more significant problems as persons grow older. As explained in earlier chapters, there is an interaction between individual human development and all aspects of a person's environment. Developmental approaches seek to optimize human potential through two major interacting avenues. One represents all that can be done to build healthy environments—biologically, socially, vocationally, and so forth. The other consists of all that can be done to help people make choices across their lifespan that will optimize individual healthy functioning in healthy environments. A healthy person operating in an unhealthy environment will be adversely affected. The same person operating in a healthy environment will be empowered toward achieving optimum development. Similarly, unhealthy persons operating in healthy environments will be positively affected and empowered to make choices to enhance their sense of well-being.

The goal of empowerment reflects a lifelong concern for helping people to live healthy lives....

Unhealthy persons operating in unhealthy environments cannot be expected to develop in positive ways, nor to achieve a sense of well-being. The goal of empowerment reflects a lifelong concern for helping people to live healthy lives and choose healthy environments in which to do so. This is a lifelong goal which can be implemented at any time of life—the earlier and more consistently, of course, the better. It is possible at any time in the lifespan to increase physical mental health and a sense of well-being through interventions which empower individuals toward healthy choices. The overwhelming advantage of preventive developmental approaches over those which stress remediation is that the goals of empowerment and achievement of optimum human potential are at once integral to human functioning and lifelong in nature.

The Wellness Philosophy

Wellness is viewed as an active process of living....

Wellness is viewed as an active process of living in which persons strive to achieve a sense of balance and integration between their mind, body and emotions (Leafgren & Elsenrath, 1986). This process is based on self-responsibility and love (Ryan & Travis, 1981).

Self-responsibility refers to the need to be assertive in creating the life you want, rather than just reacting to circumstances. It means making choices, tuning in to your body's emotional and physical messages and signals, creating and cultivating close relationships and meaningful projects, supporting others, respecting your environment, expressing and enjoying your emotions, and physical awareness. Love refers to trusting yourself and your personal resources as your greatest strengths, recognizing challenges as opportunities for growth, and loving and celebrating yourself as a "wonderful person."

Wellness approaches increase the responsibility of individuals for self-care....

...educational interventions comprise a major part of wellness approaches.

Wellness approaches increase the responsibility of individuals for self-care, thus helping them to become more self-sufficient and empowered to maintain healthy lifestyles (Hetherington & Loganbill, 1985). A major goal with older persons is to help them identify areas of their lives over which they do have control and further assist them to make healthy lifestyle choices which enhance their physical and emotional well-being. Some evidence exists that knowledge of the aging process contributes to choosing behaviors that reduce the personal impact of aging (Barbaro & Noyes, 1984). Hence, educational interventions comprise a major part of wellness approaches.

The benefits of wellness lifestyles are a better overall human existence.

The benefits of wellness lifestyles are a better overall human existence. Such a goal would seem to be desirable, yet relatively few persons consistently pursue wellness programs, individually or collectively. Apparently, it is necessary to motivate people towards wellness, somehow. Bartha and Davis (1982) suggest three reasons why people will not naturally choose a wellness lifestyle. The first is that our society tends to promote an unhealthy, dependent way of life. The media constantly provide advertisements for unhealthy products and encourage people to overeat or overdrink; they also promote dependence on drugs and medical providers to alleviate distress. Second, proper health education is lacking and typically comes after the onset of a problem. Third, we have learned to enjoy unhealthy behavior.

Wellness behaviors are intrinsically more satisfying than unhealthy habits.

Wellness behaviors are intrinsically more satisfying than unhealthy habits. In fact, people have been known to become addicted to positive behaviors (Glasser, 1976). The likelihood of first engaging in such behaviors seems to be related to the perceived ease or level of effort required and the perception of the value to be gained from the activity (Turk, Rudy & Salovey, 1984). Even if wellness behaviors are perceived as being desirable, if they are seen as very difficult the likelihood of follow through may be low. A person who is very overweight, for example, may clearly see the value of a weight loss. On the other hand, the level of sustained effort required to lose the weight and maintain the loss may be overwhelming, leading to no change at all.

With this in mind, some strategies for developing wellness in each of the six areas discussed earlier may now be considered.

Wellness in Six Dimensions

Six dimensions of wellness were identified in Chapter 3:

- emotional development
- intellectual development,
- physical development,
- social development,
- occupational development, and
- spiritual development.

Persons planning wellness interventions must be prepared to conduct needs assessments of individuals as well as organizations....

Wellness interventions may be planned and implemented in any or all of these six areas. Clearly, if people are to engage in wellness behaviors, they must understand the importance of the behaviors and consider the effort that will be required of them. Persons planning wellness interventions must be prepared to conduct needs assessments of individuals as well as organizations in order to develop programs most relevant to the persons involved and most conducive to the setting itself.

It is possible to discuss each of the six components of wellness in isolation; however, in reality they are inseparable. People function holistically, meaning that each of the six components is active at some level at all times, and that these components overlap and interact. Change in one area may be expected to influence changes in other areas. Ideally, persons will make lifestyle choices in each area to optimize their developmental potential. Such choices may be presented through individual or group educational, participatory, or counseling interventions. In all cases some baseline assessment of lifestyle behaviors will be necessary to provide the structure on which new choices may be made and implemented. Some possible strategies for working with older persons in each of the six areas are discussed below. The definitions included here were taken from Leafgren and Elsenrath (1986).

Emotional Wellness

Emotional wellness refers to feeling positive about oneself and one's capabilities. It incorporates a realistic assessment of one's capabilities and limitations and the ability to mobilize coping resources to deal with stress. Strategies presented earlier for enhancing feelings of self-efficacy are relevant here as well. Persons with a strong sense of self-efficacy and an internal locus of control will be most inclined to make healthy choices to promote their emotional wellness. In helping people make such choices, it is important to help them examine the messages they give to themselves. Wherever possible, messages of incapacity, inferiority, and fear should be replaced with messages of abilities, capacities, and freedoms to choose what one wants to do.

Emotional wellness refers to feeling positive about oneself and one's capabilities.

Assertion training is often useful with older persons to help them both express their needs and participate actively in getting those needs met. Training in stress management and mobilization of coping resources to deal with the stresses of later life also can be important. For some older persons, talking about sexuality and intimacy and methods for meeting needs in these areas is helpful. This is especially true for older women, since many no longer have access to their sexual partner yet still have needs for intimacy which may be met through other relationships.

Assertion training is often useful with older persons....

Intellectual Wellness

Colleges and universities are increasingly providing opportunities for education and intellectual growth for members of the older population. Elderhostel programs, in which older persons live on college campuses and take courses during certain academic terms, are becoming popular nationwide. Community colleges provide a variety of programs to meet the needs of older learners.

Community colleges provide a variety of programs to meet the needs of older learners.

These educational programs are only effective for those who enroll in them, and not all older persons will choose to do so. Some older persons simply do not value education as highly as others, and some have very negative memories of the classroom environment. These persons may not be motivated to pursue formal education, but could be helped to remain active intellectually through designing their own programs of reading, working, or interacting with others. Some older persons maintain intellectual stimulation through watching television game shows and trying to outguess the participants.

Many older persons do not engage in educational pursuits due to low self-esteem....

Many older persons do not engage in educational pursuits due to low self-esteem, low expectations of success, and fear of embarrassment for not doing well. Such persons can be helped to choose activities which provide them with successful experiences. An increased sense of self-efficacy will most likely lead to future lifestyle choices to remain intellectually active. A tour of a museum, a trivia contest with questions from a particular era, an historical discussion of a particular period in their lives, or a bingo game with pictures of outdated farm tools could provide a stimulating discussion for older persons who are feeling depressed and isolated.

Physical Wellness

For many persons, wellness means diet and exercise, period.

The area of physical wellness probably has received more attention in the media than any of the other areas. For many persons, wellness means diet and exercise, period. Fortunately, the physical dimension goes beyond this basic level. Physical wellness means healthy lifestyle choices in the areas of nutrition and physical exercise, but also incorporates preventive medical self-care and appropriate use of available medical care. A medical examination, including stress testing and evaluation of medications, is a necessary prerequisite to beginning a physical wellness program.

Some older persons prefer solitary leisure pursuits while others prefer to be in a group setting. Personal preferences need to be considered when designing a program. Anything—aerobic exercise, fishing, mall walking, golf—may be chosen by an older individual. Group cooking classes can provide ideas and skills for healthier eating, as well as suggestions for meals to promote weight loss or improved physiological functioning. Potluck dinners with vegetarian or heart-healthy themes can be both fun and educational as well as nutritious.

Potluck dinners with...heart-healthy themes can be both fun and educational....

Social Wellness

Maintaining harmonious relationships with others and a concern for the common environment and human welfare is what is meant by social wellness. Many older persons choose to become politically active in their community. Others decide to participate in volunteer work to benefit a particular organization or group of individuals. Not all older people want to be volunteers, however. Many are able to meet their social needs through group and club memberships and activities, or through interactions with a few close friends.

Based on what is known about the realities of later life, older persons should be encouraged to maintain a variety of memberships and friendships with persons of various ages and life circumstances. Older women whose only friendships are with their husbands and other couples, for example, may have a particularly difficult time adjusting to widowhood as couples often exclude individual older persons from their social activities.

...couples often exclude individual older persons from their social activities.

Workshops on environmental issues, political discussions and debates, and seminars on community issues can be planned for older participants. It is important that persons emerge from these sessions believing that their ideas were heard.

Occupational Wellness

Occupational wellness refers to satisfaction and enrichment through one's life work. For older persons, this can mean either work or leisure pursuits which fill the time once filled by work activities. Promoting occupational wellness may consist of job skills classes or job seeking skills classes. Older persons can be helped to prepare resumes, learn how to apply and interview for jobs, and dress for success. Panels of older persons can meet with employers to discuss the benefits of hiring older employees.

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Borders and Archadel (1987) suggest the importance of helping persons identify their self-beliefs as part of the career counseling process. Based on these beliefs, challenging learning experiences could be provided which would expand peoples' views of the work world and their career options. Structuring learning opportunities to allow "success" experiences will enhance the participants' sense of confidence and willingness to enroll in future courses.

Leisure interests are as diverse as vocational interests. Older persons can be helped to assess their leisure preferences and needs using a variety of available assessment instruments and through discussions with others concerning favorite activities. Some leisure choices can be implemented immediately, while others may require some education or training.

Spiritual Wellness

Spiritual wellness refers to the need to seek meaning and a sense of purpose in human existence.

Spiritual wellness refers to the need to seek meaning and a sense of purpose in human existence. It includes the development of an appreciation for life and the forces which exist in the universe around us. This dimension of wellness is not to be confused with formal religious beliefs. Such beliefs may form a part, even a large part, of spiritual wellness for many older persons. What is important is the opportunity to examine spiritual choices and values and reach a sense of closure or wholeness in regard to one's spiritual beliefs. This can be fostered in older persons through group discussions, individual reading and discussion and meditation.

Wellness Aspects of Agencies and Settings

The suggestions mentioned above for facilitating wellness are meant to be illustrative and certainly not exhaustive. Many more ideas for promoting wellness exist and are limited only by the creativity of the persons involved in developing and implementing them, and the requirements or rules of a particular setting or agency. Individual behavior is notoriously hard to change. Sullivan (1987) argues that the best way to change individual behavior is through creating a positive, healthy environment. He further stated that "development is most likely to occur in environments that are aware of systemic relationships and where developmental changes are anticipated, planned, and celebrated!" (p. 26).

...the best way to change individual behavior is through creating a positive, healthy environment.

In support of the importance of the setting, Maysey, Gimarc and Kronenfeld (1988) stressed the need for training of staff as a starting point for wellness efforts. They emphasized the multiplier effect which occurs when the health habits of a few influential persons are changed. Staff serve as role models and mentors for others, and thus have the capacity to greatly influence the implementation of any given wellness strategy.

Another key to successful implementation of wellness programs is the use of an advisory panel. An advisory panel should include members of the staff and administration, and most importantly, representatives of the persons to be affected by the changes—the clients or residents. Advisory panels can assist in assessing needs; developing, implementing, and evaluating programs; and setting goals and priorities. They can enhance the chances for program success by generating grass-roots support. Of course, it is essential that those in positions of power actively seek and use

...key to successful implementation of wellness programs is the use of an advisory panel.

the advice of advisory panels in program development efforts. In doing so, they must exemplify the essence of the wellness philosophy: a sincere belief in the capability of individuals to assume responsibility for their own total well-being. Such a philosophy is inherently empowering.

Wellness as a Lifespan Concern

If one chooses to define society as a large, diverse and complex organization, then Bennis' (1987) concept of leadership is relevant. He defines leadership as the force which gives pace and energy to work and is felt throughout an organization. Most importantly, Bennis believes that "empowerment is the collective effect of leadership" (1987, p. 199). Empowerment requires effective leadership and is evidenced in four major themes:

..."empowerment is the collective effect of leadership."

1. people feel significant and that they make a difference; what they do has both meaning and significance.
2. learning and competence are important; failure is non-existent; mistakes lead to useful feedback for future plans.
3. people are part of a community; they feel part of a team, a family.
4. work is exciting, stimulating, challenging, fun; motivation is provided through identification and pride.

These themes of empowerment parallel the benefits of wellness described earlier. They share the common philosophy of encouraging people to take responsibility for the lifelong choices which affect their lives. Hettler (1984) noted that "it seems ludicrous to prepare students for a lifetime career...and not prepare them for...maintaining life" (p. 17). When people are viewed holistically, it is necessary to consider each of the components of wellness in developing a sense of

..."it seems ludicrous to prepare students for a lifetime career...and not prepare them for...maintaining life."

self-responsibility and choice. Similarly, it is necessary to consider these components longitudinally, over the course of an individual's lifespan.

As persons grow older, the interaction between the various components of development or wellness increases. Small changes in one area can contribute to major changes in other areas, for better or for worse. The Social Reconstruction Model implies that positive changes in any one area can contribute greatly to positive changes in other areas. Thus, while holistic wellness is optimum, positive lifestyle choices in any of the six areas of wellness are to be encouraged. This is true for persons of any age as well as for older persons.

What is true as we grow older, however, is that the cumulative effect of lifestyle choices becomes increasingly significant. The negative impact of unhealthy choices will be much more dramatic among older individuals. The good news is that it is never too late to change, and that positive, healthy lifestyle choices can enhance the quality of life, across the lifespan, beginning whenever they are implemented. It is up to us to make those choices, first of all for ourselves, and second of all to allow us each to serve as role models and mentors for others to encourage them to develop a healthy lifestyle. Empowerment begins "at home" and has an immeasurable ripple effect. Creating a world where empowerment is the norm is a challenge we all face. A philosophy of wellness extending across the lifespan is one way to respond to this challenge.

The negative impact of unhealthy choices will be much more dramatic among older individuals.

Epilogue

She sat in a chair in the corner of her hospital room staring blankly at her son. "Mom, you get confused sometimes, so you can't live alone anymore," he told her. "Why? I don't understand. I don't remember being confused!" she replied. Her son, exhausted from lack of sleep, sighed deeply. This latest episode had begun with a family visit. After retiring for the evening she got out of bed every 15–20 minutes over the course of the night. She was fearful, bitter with recriminations, and apparently hallucinating. Where was the sweet, sociable, loving mother he knew? As he looked at her frail, 95-pound frame, his heart ached for her. Four days had passed since she was once again admitted to the hospital with low potassium—no doubt the result of not eating properly. After ten years of comfortably living alone, why was she now having so many problems? Most importantly, was she also suffering from something else—possibly Alzheimer's disease?

She was fearful, bitter with recriminations, and apparently hallucinating.

After ten years of comfortably living alone, why was she now having so many problems?

He smiled as he remembered her conversation with the nurse the evening before. The nurse was tired, ready to go home, complaining a little. His mother also wanted to go home. She asked the nurse why she stayed. The younger woman replied that she was waiting for the check at the end of the month. His 76-year-old mother laughed, "That's the difference between you and me, dear. At the end of the month you get a check. At the end of the month I write a check!" Everyone laughed. How could she

> seem so alert, witty, and bright—so normal? And then, a few minutes later, become another person: angry and demanding, so frustrating to be around. And, how could he even begin to answer her questions: "Why can't I go back to my apartment? Why are you doing this to me? Can I get a second opinion?"

One of the greatest challenges of empowerment… arises late in life, when physical and emotional strength declines….

One of the greatest challenges of empowerment with older persons arises late in life, when physical and emotional strength declines in response to a lifetime of wear and tear and sometimes also specific disease processes. We all have our ups and downs. For frail older persons, feeling up may be synonymous with a need and desire to remain living independently. Feeling down, and requiring help with daily needs, is as undesirable in later life as at any other time. Helping older persons feel a sense of empowerment when their needs are greatest can only be accomplished if we pursue a philosophy and process of empowerment in earlier years.

C. Gilbert Wrenn, a distinguished scholar of the counseling profession, moved with his wife Kathleen into a life-care community when they turned 80 years of age. Such communities provide a graduated living environment: residents can progress from independent houses to apartments to assisted living to a nursing home. Among the many reasons the Wrenn's gave for their decision was the desire to make the move while still healthy enough to survive the stress of moving a lifetime of possessions from a large house into a small apartment. They also wanted to establish a strong support network in case something happened to one of them. They chose an apartment in the building with the nursing home. In the event one of them needs nursing care, the other will be nearby, in the same building. Gilbert and Kathleen made a lifestyle choice which will result in their maintaining control and personal power throughout the remainder of their lifespan. They were able to do so because a life-care

Gilbert and Kathleen made a lifestyle choice which will result in their maintaining control….

facility was available and within their financial means. At first their son was surprised, but later supported the move. Why should they not make whatever choices were important to them to maintain the control of their own lives they had always before experienced?

Again, one of the keys to empowerment in later life is empowerment earlier in life, ideally across the lifespan. It is unrealistic to expect that all barriers to development can be removed, or that a utopian society could be created. What is perhaps more realistic is to find a means of helping people cope with the varied circumstances in their lives in a manner which allows them to live with dignity, respect, and a sense of self-esteem, regardless of their material circumstances. That means is embodied in the concept of empowerment, a strategy which can eliminate the impact of arbitrary decisions which limit the choices and life satisfaction of persons in their later years.

...one of the keys to empowerment in later life is empowerment earlier in life....

As we enter the 1990s, our challenges for the future are many. We must create a society which values empowered citizens. We must create and foster agencies and settings which serve as role models for empowerment. Finally, we must encourage all persons, especially older persons, to assume a sense of freedom and responsibility for the choices they make in their lives.

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ERIC Resources

EJ397263 SP518915

Programs for the Aging Population. Professional Standards Development.

Boarman, A. Marie

Journal of Physical Education, Recreation and Dance, v60 n3 p77-78 Mar 1989

Available From: UMI

Language: English

Document Type: JOURNAL ARTICLE (080); POSITION PAPER (120)

Journal Announcement: CIJFEB90

This article provides an overview of recent AAHPERD activities in aging and adult development, with emphasis on the need for qualified leaders and practitioners in the areas of physical activity, exercise, health promotion, and recreation for older adults. (IAH)

EJ394419 SP518695

Implications for Fitness Programming—-The Geriatric Population.

Brown, Stanley P.; And Others

Journal of Physical Education, Recreation and Dance, v60 n1 p18-23 Jan 1989

Available From: UMI

Language: English

Document Type: JOURNAL ARTICLE (080); GENERAL REPORT (140)

Journal Announcement: CIJDEC89

This article discusses the relevance of fitness programing for an aging population and provides parameters for a geriatric fitness program. Emphasized are physical activity as a preventive measure against age-related illness and management of a geriatric fitness program. (IAH)

EJ391653 CE520514

The Subjective Experience of Aging: Correlates of Divergent Views.

Connidis, Ingrid

Canadian Journal on Aging, v8 n1 p7-18 Spr 1989

Language: English

Document Type: JOURNAL ARTICLE (080); RESEARCH REPORT (143)

Journal Announcement: CIJNOV89

Four hundred community-dwelling older persons were asked about their age and if they were worried about growing older. Results showed significant relationships between dependent variables and characteristics including age, health, expectations of older age, and gender. Respondents held a positive view of old age that was coupled with an appreciation of the shortcomings that it includes. (JOW)

EJ396211 CG536165

Predictors of Loss Management and Well-Being in Late Life Widowhood and Divorce

Farnsworth, Judy; And Others

Journal of Family Issues, v10 n1 p102-21 Mar 1989

Available From: UMI

Language: English

Document Type: JOURNAL ARTICLE (080); RESEARCH REPORT (143)

Journal Announcement: CIJFEB90

Examined data from 219 widowed or divorced older adults. Found that self-reported personal health was a major predictor of management of loss and well-being for both divorced and widowed respondents with positive ratings of health consistently indicating more satisfactory outcomes. For widowed respondents, time since spouse's death was strong predictor of management of loss and well-being. (Author/NB)

EJ396207 CG536161

Social Support Coverage and the Well-Being of Elderly Widows and Married Women

Greene, Ritsuko Watanabe; Feld, Shelia

Journal of Family Issues, v10 n1 p33-51 Mar 1989

Available From: UMI

Language: English

Document Type: JOURNAL ARTICLE (080); RESEARCH REPORT (143)

Journal Announcement: CIJFEB90

Examined relationship between social support coverage and well-being in four subgroups from national sample of women over age 50: first married (N=151); widows (N=144); widows within last 5 years (N=60); and widows for over 5 years (N=84). Results revealed that relationships between social support and well-being were positive in some groups and negative in others. (Author/NB)

EJ397524 CG536345

Regrets and Priorities at Three Stages of Life.

Kinnier, Richard T.; Metha, Arlene T.

Counseling and Values, v33 n3 p182-93 Apr 1989

Available From: UMI

Language: English

Document Type: JOURNAL ARTICLE (080); RESEARCH REPORT (143)

Journal Announcement: CIJMAR90

Surveyed 316 men and women from three categories (20-29, 35-55, and 65 or older) about their major regrets and priorities in life. The most frequently cited regrets were related to missed educational opportunities and failure to have been more assertive and to have taken more risks. Differences were found between age groups; gender differences were also revealed. (Author/NB)

ED286015 CE048298

Wellness for Older Workers and Retirees. WBGH Worksite Wellness Series.

Levin, Robert C.

Washington Business Group on Health, Washington, DC. p70 Jan 1987; For related documents, see CE 048 292-305

Sponsoring Agency: Public Health Service (DHHS), Rockville, MD. Office of Disease Prevention and Health Promotion

Available From: Prevention Leadership Forum, Washington Business Group on Health, 229 1/2 Pennsylvania Ave., SE, Washington, DC 20003 ($15.00).

EDRS Price - MF01 Plus Postage. PC Not Available from EDRS.

Language: English

Document Type: REVIEW LITERATURE (070)

Geographic Source: U.S.; District of Columbia

Journal Announcement: RIEFEB88

Company-sponsored wellness programs are particularly important for older employees inasmuch as they are at greater risk of disease and disability than are their younger counterparts and their health care and health insurance costs are generally higher. As the cost of retirement benefits rises, wellness programs for retirees are becoming increasingly important. Wellness programs intended for older workers and retirees may focus on one or more of the following: medical screenings, health information, health classes and seminars, and exercise and fitness programs. Physician involvement and support, spouse eligibility, focus on risk factors, emphasis on managing chronic illness knowledgeable and enthusiastic staff, recognition of individual achievement, focus on retirement planning or on a retiree club, and caution in using an age focus are all factors that have been found to be associated with program success. Although worksite wellness programs have not traditionally focused on older workers or retirees, companies that have instituted such programs have found them worthwhile for their cost-effectiveness and their inherent social value. Wellness programs for older and retired employees can be especially effective when companies recognize the varied abilities and interests of retirees of different ages and when programs are designed with consideration for such barriers as access to programming, legal liability, difficulty in effecting behavioral change, and lack of consensus about effective interventions. (Twenty-seven examples of companies that offer wellness programs for older employees and retirees are included in this document.) (MN)

EJ396257 CG536250

The Frustrations, Gratifications, and Well-Being of Dementia Caregivers.

Motenko, Aluma Kopito

Gerontologist, v29 n2 p166-72 Apr 1989

Available From: UMI

Language: English

Document Type: JOURNAL ARTICLE (080); RESEARCH REPORT (143)

Journal Announcement: CIJFEB90

Interviewed 50 older women who were caring at home for a husband suffering from dementia. Examined patient's illness, marital relationship, cognitive age and a variety of socio-demographic variables. Tested hypothesis that it is important for wives to care for sick husbands to maintain their own sense of well-being. (Author/BHK)

EJ396268 CG536261

Financial Experience and Well-Being among Mature Widowed Women.

O'Bryant, Shirley L.; Morgan, Leslie A.

Gerontologist, v29 n2 p245-51 Apr 1989

Available From: UMI

Language: English

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Journal Announcement: CIJFEB90

Analyzed 300 widowed women, age 60 or older, regarding financial experience prior to widowhood, planning undertaken before death of spouse, and effects on well-being in early widowhood. Results indicated that preparation was associated with somewhat better well-being among widows, but financial experience prior to widowhood had no effect. (Author/BHK)

EJ397260 SP518912

The AAHPERD Fitness Task Force. History and Philosophy.

Osness, Wayne

Journal of Physical Education, Recreation and Dance, v60 n3 p64-65 Mar 1989

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Journal Announcement

The AAHPERD Physical Fitness Task Force was formed to develop an effective and appropriate health status test for older adults. This article describes the procedures employed by the Task Force to develop and validate the test. (IAH)

ERIC/CAPS

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What challenges to growth are faced by older persons? Most importantly, what encouragement is provided to this population for continued growth, continued risk taking? In this monograph, Jane Myers, noted authority on aging, poses these questions and concludes that in our society we limit the behavior of older individuals based on the very arbitrary criterion of chronological age.

Dr. Myers proposes empowerment—gaining a sense of personal power or control over one's life—as the antidote for older persons who face devalued status as they age and the accompanying drop in self-esteem and self-worth. She explores the concept of empowerment in detail, reviews developmental issues key to understanding the aging process, and ends with a discussion of empowerment strategies through a holistic wellness model.

Older persons and the counselors, caregivers and educators who would be of help to them will benefit immensely from this monograph, as will adults of *any* age who wish to enhance and empower themselves.

[illegible] book for adult helpers and all adults who wish to [illegible] themselves ... up-to-date and well researched...will lead [illegible]

—C. Gilbert Wrenn

[illegible] and often reaches the reader [illegible]

— [illegible]

[illegible] of gerontological counseling.

— [illegible]

[illegible] N.C.C., L.P.C.C., is the 1990-91 [illegible] Association for Counseling and Development [illegible] of Counseling and Specialized [illegible] the University of North Carolina at [illegible] lectured and consulted nationally and [illegible] of aging.

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